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Joint Committee on the Draft Mental
Health Bill

Draft Mental Health Bill 2022

Report of Session 2022–23

*Report, together with formal minutes relating to
the report*

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Joint Committee on the Draft Mental Health Bill

The Joint Committee on the Draft Mental Health Bill was appointed by the House of Lords and the House of Commons to consider the Government's draft Bill to reform the Mental Health Act 1983, including changes to the safeguards and support received by patients.

The Joint Committee had a maximum of six Members appointed by each House, of whom the quorum for any formal proceedings is two from each House.

Current membership

House of Commons

Dr Rosena Allin-Khan MP (*Labour, Tooting*)

Marsha De Cordova MP (*Labour, Battersea*)

Jonathan Gullis MP (*Conservative, Stoke-on-Trent North*)

Dr Dan Poulter MP (*Conservative, Central Suffolk and North Ipswich*)

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Powers

The Committee had the power to require the submission of written evidence and documents, to examine witnesses, to meet at any time (except when Parliament is prorogued or dissolved), to undertake visits within the United Kingdom, to appoint specialist advisers, and to make Reports to both Houses.

Publication

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Committee staff

The staff of the Committee was Zara Bernard (Committee Specialist), Laura Caccia (Second Commons Clerk), Rupert Grist (Deputy Counsel), Siddhant Gurung (Committee Operations Officer), Ian Hook (Senior Executive Officer), Anne Peacock (Media and Communications Manager), Susan Ramsey (Committee Operations Officer), Billy Roberts (Media and Communications Officer), Bruce

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Summary

The draft Bill arises out of the 2018 Independent Review of the Mental Health Act 1983, chaired by Professor Sir Simon Wessely. The Review made recommendations to address the rising number of people detained under the Mental Health Act (MHA), especially 'black or black British' people who are four times more likely to be detained than people from 'any white background'. We have not addressed everything in the Independent Review, nor repeated its detailed analysis of the case for change. We have focused on improving the draft Bill in front of us, to better achieve the Review and the Government's aims. This should not be the end of the reform process. There should also be an ongoing process aimed at more fundamental reform of the MHA.

We welcome the draft Mental Health Bill. It makes important changes to introduce more

choice, accountability, and oversight into the use of the MHA. We also heard arguments for entirely new legislation, bringing together mental health and mental capacity legislation and focusing the legal framework on patients' rights. We believe the measures in the draft Bill should be strengthened as set out in this report and brought forward at the earliest opportunity. We recommend that the four Principles that the Independent Review structured their work around—choice and autonomy, least restriction, therapeutic benefit, and the person as an individual—should be included on the face of the Bill.

Whilst we welcome the Government's reforms, proper resourcing and implementation will be crucial. Most witnesses were unconvinced that the Government's resourcing plans were adequate. Mental health services are under significant pressure and, in a difficult fiscal environment, transparency and accountability

will be key. The provision of high-quality community alternatives to inpatient care are especially crucial. The Government should publish a detailed plan for resourcing and implementation on introduction of the Bill and be required to report annually on progress during the implementation period.

To help drive the ongoing process of reform and ensure accountability for implementation we recommend the creation of a Mental Health Commissioner. They would oversee the direction of travel for the key reforms arising from the Bill and their implementation, monitoring outcomes and supporting cultural change. They should be an advocate for patients, their families and carers and speak up about the stigma still attached to severe mental illness. They should bring forward proposals to tackle inequalities in service provision and

the operation of the MHA, advise patients and providers on complaints procedures and make recommendations on further reform.

Data shows that the racial and ethnic inequalities that the Independent Review was set up to tackle have not improved since the Review was commissioned. This is unacceptable. We recommend that all health organisations be required to appoint a responsible person to collect and publish data on, and oversee policies to address, racial and ethnic inequalities. A statutory right to culturally appropriate advocacy should be established, learning lessons from the current pilots. Community Treatment Orders are 11 times more likely to be given to black patients than white patients and this figure is rising. The evidence we heard suggests they are ineffective for most patients. We recommend they are abolished for Part II patients (those not involved in the criminal justice system), and a statutory

process and timeline be put in place for their review and potential abolition for Part III patients (those involved with the criminal justice system).

The draft Bill makes changes to the grounds on which someone can be detained for assessment and treatment. These changes are intended to increase accountability, to move away from an abstract notion of risk and to require evidence that detention will benefit the patient.

The aims of these changes are welcome, but we recommend clearer guidance and tighter drafting to ensure they are not used to turn away those who need help, especially those who seek it voluntarily or for whom an earlier and shorter intervention may be more beneficial. The changes made to the detention criteria in Part III of the Act are not the same as those made to Part II of the Act. Whilst justified in some cases, we heard it means the draft Bill as it stands could lead to an increase in the number of people detained under Part III. This would be contrary to the intention of the draft Bill. We

recommend the changes in the detention criteria are made consistent between Parts II and III of the Act.

Too many autistic people and people with learning disabilities are being detained in inappropriate mental health facilities, and for too long. We welcome the Government's proposals to address this, but have heard concerns that the removal of autism and learning disability as grounds for detention under Section 3 of the MHA may lead to more detentions under different legal powers, with fewer safeguards, or diversion into the criminal justice system instead. This would be the opposite of what the change is intended to achieve. Proper implementation of community care improvements and stronger safeguards against inappropriate detention will be vital. We make detailed proposals on these, including stronger duties on health and care bodies to proactively identify those in need of community care and provide it, a process to ensure the change only comes into force once

community care provision has significantly improved, and a tightly defined power under the MHA aimed at ensuring particularly complex cases where detention might be thought to be warranted are considered by a specialist Tribunal from the outset.

The ability of patients to make choices about their care and treatment was identified as one of the single most effective measures to reduce detentions and improve inequalities. We welcome the draft Bill's provision for statutory Care and Treatment Plans and recommend that all patients who have been detained under the Mental Health Act should also have the statutory right to make advance choice documents, covering care and treatment, and have support in doing so. Similarly, the draft Bill's proposal to give patients choice over who should make certain decisions on their behalf is a major step forward, but more work needs to be done to ensure the process is manageable and does not conflict with existing legislation when applied to

under 18s. We also recommend that “opt-out” advocacy, whereby patients will be proactively offered the support of an advocate, should be extended to voluntary patients when sufficient capacity has been developed in the workforce to allow it.

The upcoming legislation will be a crucial opportunity for the Government to strengthen the rights and protections for children and young people under the MHA. For example, by introducing stronger requirements to avoid the placement of children in adult or out of area wards, and by consulting on a statutory test for ‘child capacity’ to ensure that children and young people have equal access to the safeguards in the draft Bill that rely on a patient’s ability to make their own choices.

Finally, the draft Bill contains positive proposals in relation to Part III patients, including the statutory time limit of 28-days to transfer patients from prison to hospital and the removal of

prison and police stations as “places of safety”. We are concerned, however, that the proposal for a conditional discharge that amounts to deprivation of liberty may be overused, especially for ethnic minorities. We recommend that the use of this provision should be closely monitored, with a statutory review after three years.

Our proposed changes are designed to strengthen the draft Bill, to provide a voice speaking up for patients and driving ongoing reform and to mitigate potential unintended consequences. We look forward to the Government introducing the final Bill into Parliament within this Session.

1 Introduction

The Mental Health Act

1. The Mental Health Act 1983 (henceforth, “MHA”) is the main piece of legislation that governs the treatment of those with ‘mental disorders’. It allows for compulsory admission to hospital (“detention”) in certain circumstances, sets out the processes to be followed in such cases and gives rights of appeal to the Mental Health Tribunal. Part III of the MHA addresses those who have mental illnesses who are in the criminal justice system—so-called “forensic patients”. The MHA has been amended multiple times, most relevantly for our purposes in the Mental Health Act 2007.

2. Detentions under the amended MHA have been rising year-on-year since comparable data was first published in 2016–17—from 45,684 to 53,337 in 2021–22. At the same time, there have been marked racial disparities, with ‘black or black British’ people being over four times

more likely to be detained than people from ‘any white background’. In 2017 the then-Prime Minister, Rt Hon Theresa May MP, established an Independent Review to consider:

Why rates of detention were increasing—
what could be done to reduce
inappropriate detention and improve how
different agencies respond to people in
crisis; and

reasons for the disproportionate
number of people from certain ethnic
backgrounds, in particular black people,
being detained under the act, and what
should be done about it.

3. The Review was chaired by Professor Sir Simon Wessely. Its report, *Modernising the Mental Health Act: Increasing choice, reducing compulsion* was published in December 2018 (henceforth “the Independent Review”). The Government responded with a White Paper, *Reforming the Mental Health Act*, in January

2021 (henceforth “the White Paper”) and a consultation process to which it responded in August 2021. The draft Bill to amend the Mental Health Act was published on 27 June 2022 as the next stage of that consultation process.

Our inquiry

4. We were appointed on 19 July 2022 with a deadline to report on the draft Bill by 16 December 2022. The suspension of parliamentary business owing to the death of the late Queen in September 2022 meant that we had to delay some of our meetings by several weeks. Accordingly, both Houses agreed to extend our deadline to 13 January 2023.

5. During our inquiry we have heard formal, public evidence at 12 meetings, hearing from over 50 witnesses. We also visited the mental health facilities at Lambeth Hospital and held a virtual roundtable event with service users from around the country. We received 114 submissions of written evidence and issued an

online survey, including in 'easy read' format, which had over a hundred responses. We are very grateful to everyone who took the time to contribute to our inquiry and in particular our two specialist advisers - Professor Kamaldeep Bhui, Professor of Psychiatry and Hon. Consultant Psychiatrist, University of Oxford, and Dr Hugh Jones, Joint Clinical Director for Patient Safety, South London and Maudsley NHS Trust.

Pre-legislative scrutiny process

6. We strongly welcome the Government's decision to submit this draft Bill to pre-legislative scrutiny, as the Chair and Vice-Chairs of the Independent Review wished. We are grateful to the Department for Health and Social Care and to the Ministry of Justice for their assistance and co-operation during our work.

7. We recognise that the timetable for pre-legislative scrutiny is necessarily tight. Those who wish to submit evidence have only a short period of time in which to do so. This can be

particularly challenging for individuals and smaller organisations. In our case, this period also coincided with the summer holidays, which probably impacted response rates. At the same time, we were aware that the Government and Independent Review had undertaken extensive consultation, including with service users, during the lead up to the draft Bill. This will not always be the case. The Government could in future help potential respondents prepare for the pre-legislative scrutiny process by directing interested parties to parliamentary information on pre-legislative scrutiny and select committee work when publishing a draft Bill.

8. To facilitate early engagement with future pre-legislative scrutiny, we recommend that the Cabinet Office's Guide to Making Legislation include wording for Bill Teams to include in press notices announcing future draft Bills. This should advise readers on the upcoming scrutiny process and direct them to where further information can be

found. This wording should be agreed with officials in the Scrutiny Unit in both Houses of Parliament.

Extent

9. The substantive provisions of the draft Bill extend to England and, with some exceptions, Wales. We sought evidence from English and Welsh stakeholders, including the Senedd Health and Social Care Committee, and their views are reflected in this report. We also sought the views of the Welsh Government. They told us that they were broadly supportive of the draft Bill and would continue to work closely with the UK Government on it.

Structure of this report

10. This report does not cover everything in the Independent Review, nor repeat its detailed analysis of the causes for rising detention rates or the case for change. We have focused on seeking to improve the draft Bill in front of us, to

better achieve the Review and the Government's aims. We have focused our scrutiny on the key areas below.

11. In chapters two, three, and four of this report, we address overarching issues that cover the draft Bill as a whole: its overall approach and place within the wider picture of Mental Health Act reform, its approach to tackling the racial and ethnic inequalities that were key to the Government's establishment of the Independent Review and the resourcing and implementation plans that the Government has laid out to support it.

12. Chapter five examines the changes to the grounds for detention that were at the heart of the Independent Review. Chapter six looks at the proposed exclusion of autism and learning disability from the grounds for detention in Section 3 of the MHA and related changes. Chapter seven considers how the draft Bill might impact children and young people.

13. Chapters eight, nine and ten look at various aspects of the draft Bill's approach to giving patients more of a voice in their choice of treatment and care. Chapter eight considers Care and Treatment Plans and advance choice documents, Chapter nine examines the replacement of the "Nearest Relative" with a "Nominated Person", and Chapter ten addresses the role of mental health advocates.

14. Chapter 11 addresses the proposed changes to Part III of the MHA, which affects those who encounter mental health services through the criminal justice system. Chapter 12 looks at management and support for those experiencing a mental health crisis, particularly in A&E.

15. Finally, Appendix one summarises the responses to our survey, Appendix two summarises the virtual roundtable we held with service users and Appendix three contains our observations on drafting points in the draft Bill.

2 Overall Approach

16. The draft Bill amends the Mental Health Act (MHA) 1983, primarily to implement recommendations of the 2018 Independent Review. It also includes some other measures that were not recommended by the Review, such as the removal of learning disability and autism as potential grounds for detention under Section 3 of the MHA. The aim of the Independent Review's 154 recommendations was to "shift the dial" away from coercion and towards patient choice, thereby reducing detentions and inequality.

17. Only a relatively small number of recommendations in the Independent Review required or lent themselves to legislation. The draft Bill therefore sits within a much larger programme of cultural and policy change. Some of this is set out in the Government's response to the Independent Review, the Long-Term Plan for the NHS, the Building the Right Support

Action Plan aimed at support for people with learning disabilities and autistic people, and the expected 10 Year Plan for Mental Health.

18. The draft Bill was welcomed by most of those we heard from, including patients' groups, professionals, service users and academics. Professor Sir Simon Wessely, Chair of the Independent Review, and the Review's vice-chairs were "very satisfied" with it, although there were areas where they felt their recommendations had been watered down or "lost" which we will discuss later in this report. There was strong support in the evidence we received for the draft Bill, as containing important reforms and a "positive direction of travel", though again this was often caveated by a desire to go further or more closely reflect the Independent Review's recommendations. Responses to our survey were, on balance, positive about the draft Bill as a whole. There was strong support for the proposition that it would improve patient choice, and there was a

majority (though much smaller) agreeing with the statement that it would ensure admissions under the MHA only took place “when strictly necessary”.

19. As we shall see in later chapters, concerns were expressed in evidence, the survey, and our roundtable about specific measures, about funding and implementation, and about unintended consequences. When concern about the direction of travel was expressed, it was generally that measures to reduce the rate of detention could lead to people not getting the care they need—an issue we will return to in Chapters 4 and 5. However, the overall tone of our evidence was positive, with only a small minority expressing opposition or concern about the draft Bill as a package.

Fundamental reform versus amending legislation

20. Notwithstanding the broad support outlined above, there was a view among some

of our witnesses, survey responses and at the roundtable with service users that more fundamental reform of the MHA is required or would be desirable. This was generally on one or more of three grounds, which often overlapped:

- The MHA's structure and assumptions are out-dated. Frequent amendments have made the legislation complex and difficult to use and have led to unintended consequences. We received evidence from an experienced mental health lawyer describing some of the interactions under the MHA as "bewildering". Some of the provisions in the draft Bill itself are also very difficult to understand. We have recommended in Appendix 3 that the wording of some of these provisions is reconsidered to make them more user-friendly. But this complexity is at least partly a consequence of many years of accumulated, piecemeal changes.

- The difficulties and complexities of the interaction between the MHA and the Mental Capacity Act 2005 have been a constant theme in our evidence. Examples of this are included in the Chapter 6 on learning disability and autism and Chapter 12 on crisis management. The situation was described to us by an academic expert as “a real mess”. Some witnesses saw the failure to address the interaction as a missed opportunity. Some argued for entirely new legislation, replacing the dual framework with a single piece of legislation, so-called “fusion legislation”. For some, this was a human rights issue, arguing the existence of legislation to compel people with decision-making capacity to undergo treatment is based in a discriminatory and unwarranted assumption that people with mental illness are inherently unable to make decisions for themselves. Indeed, a majority of our survey respondents

disagreed with the statement that “The current law, which treats physical and mental illnesses differently regarding patient consent to treatment, takes the right approach”.

- Some witnesses wanted the MHA replaced with new legislation that starts from the rights of service users, rather than the power to detain them. They saw the MHA as a fundamentally coercive piece of legislation that needs to be replaced to respect the rights of patients, in particular those rights set out in the UN Convention on the Rights of Persons with Disabilities. Witnesses who advocated for this view saw the lack of positive rights in the MHA as a serious issue that predisposed the system towards coercion, noting that the only rights to care came as a result of compulsory admission, without a corresponding right to community care.

21. We heard from Sir Simon that the Independent Review's decision to recommend amending legislation came from a mixture of pragmatism, a concern to ensure change was consensual, and a desire to follow developments in other jurisdictions before committing to fundamental change. This was a different conclusion to other, similar, processes held elsewhere in the UK. The 2007 Bamford Review of Mental Health Legislation and Learning Disability recommended "fusion" legislation in Northern Ireland. This was passed in the form of the Mental Capacity (Northern Ireland) Act 2016, though we heard that it has not been fully implemented or commenced yet. John Scott KC's 2022 Scottish Mental Health Law Review saw its role as shifting mental health law from primarily being about "authorising and regulating actions which may limit a person's autonomy" to "one where a person's rights are respected, protected, enabled and fulfilled".

The Independent Review team saw these developments as a potential evidence base for future reform in England and Wales.

22. A final factor that has developed since the Independent Review took place is urgency. There was a clear sense from our witnesses that key reforms in the draft Bill could not afford to wait for a more radical change—even where they saw such change as desirable. The growing disproportionality in the application of the MHA to black people, the number of people in long-term detention without therapeutic benefit, a lack of trust in the system and the recent scandals about abuse in care settings all pointed in the direction of change being needed urgently. As Baroness Neuberger, one of the Vice Chairs of the Independent Review, put it:

Although it seems to me that there is a very strong argument for a complete, fundamental review and a new Act—I do not doubt that—it is not only a question

of the length of time it would take to get it; it is about the effect on people who use the services if we do not do something more quickly. There has been a four year delay since we published the review. There are some things that we are recommending that will make a great deal of difference to service users. I think we should get them through.

23. The draft Bill has been widely welcomed by those we heard from during our inquiry. It contains important reforms developed, for the most part, over more than five years through a consensual process involving professionals, service users, the Government and Independent Review team. We welcome the draft Bill and would like to see it introduced in this Session of Parliament.

24. The Mental Health Act 1983 is nearly forty years old. It has been amended

multiple times over those years, making it hard to use even for experienced professionals. It is overly complex, especially where it interacts with the Mental Capacity Act 2005. It is focused on coercive powers rather than patients' rights. The draft Bill with our proposed amendments will help, but it should not be the end—or even a pause—in the process of reform of mental health legislation.

25. *We recommend that there should be an ongoing process of mental health legislation reform, leading in the direction of more “fused” and rights-based legislation and learning from developments elsewhere in the UK and overseas. In advance of this work, the Government should look for opportunities to amend the Code of Practice to improve the justification required for clinical decisions to use the Mental Health*

Act where a patient has decision making capacity and is refusing admission and treatment.

A Mental Health Commissioner

26. A central theme of both the Independent Review and the draft Bill has been improving patient choice and advocacy. In recommending that there should be an ongoing process of reform, we were aware there is no independent voice advocating for service users set out in statute. This contrasts with the way that, for example, the Children's Commissioner advocates for the interests of children, or the Victim's Commissioner for victims of crime.

27. Under the MHA, the Mental Health Act Commission was, amongst other things, charged with reviewing the operation of the MHA, making recommendations for changes to the Code of Practice and advising the Secretary of State on policy matters. The Commission was abolished in April 2009 and its functions

in respect of the Mental Health Act moved to the Care Quality Commission (CQC). The Commission can, and does, review the MHA, make recommendations, hear complaints and seek the views of service users. At the same time it is first and foremost a regulator, with a broad remit across the health and social care sector. We heard concerns that this could lead some of its functions in respect of the rights of mental health patients to be overlooked.

28. The Parliamentary and Health Service Ombudsman (PHSO) also has a role in supporting service users. PHSO resolves complaints that have not been satisfactorily dealt with and makes recommendations on their findings. However, it is neither an advocacy service nor a “consumer champion”. Evidence from PHSO noted the complexity of the multiple complaints processes that exist, the difficulty service users and carers experience in using them and lack of transparency around signposting of such routes. PHSO made

recommendations, supported by the CQC, about using the draft Bill to streamline and require sign posting of complaints processes including mandatory signposting and setting out clearly what each organisation's role is. At the same time, we heard that what was needed was not adding more legislative change or powers, but rather promoting cultural change and good practice in complaints and investigations.

The Government, in its response, said it was "sympathetic" to PHSO's recommendations, but that legislation was not required to achieve them. It also pointed to Clause 35 of the draft Bill, which requires hospitals to make information about complaints procedures available to detained patients.

29. The stigma associated with the MHA came up repeatedly during our inquiry. The Independent Review discussed the increased willingness in recent years to openly discuss mental illnesses in its report and felt attitudes had improved since the last Review of the MHA,

in 1999. Yet they noted, and we heard during our inquiry, that the stigma attached to mental illness is very much still present. We heard this is especially true where severe and enduring mental illness is concerned and where the MHA is involved. It is worth reflecting on the disparity between the relatively large amount of evidence that we received that related to adults experiencing non-psychotic disorders compared to the relatively small amount of evidence explicitly relating to psychotic disorders. We have concerns that this trend may continue in future attempts at reform and that this may be conceptualised as another manifestation of stigma. This stigma can significantly impact on people's life chances and care, not just for their mental health but their physical health as well. We also heard that it can sometimes be difficult for families and carers to be taken seriously by professionals and that there is a lack of institutional voices speaking on their behalf.

30. *Effective handling of complaints is an important part of ensuring patients feel their voices are heard and services improve from a service user perspective. We recommend that the Government adopt the Parliamentary and Health Service Ombudsman's recommendations on streamlining and signposting complaints processes.*

31. Patient choice and advocacy has been central to the Independent Review and the draft Bill. We were struck during our inquiry that there is no independent figure to advocate on behalf of those who are detained or are likely to be detained under the Mental Health Act or their families and carers. Such statutory roles exist in other fields, for example the Children's and Victim's Commissioners. We see advocacy as especially important to challenge the stigma that still attaches to mental illness and the Mental Health Act, especially in relation to severe and enduring conditions

such as schizophrenia. Such an advocate would be well placed to ensure that the process of reform does not end with this draft Bill.

32. *We recommend that the post of a statutory Mental Health Commissioner and should be created, with the support of an Office. Their role should include:*

- a) *Being a voice at the national level promoting the interests of those who are detained, or are likely to be detained, under the Mental Health Act, and of their families and carers, raising awareness of their needs, and challenging stigma and stereotypes;*
- b) *Working in conjunction with the Care Quality Commission and other bodies to make recommendations on reforming mental health law in the direction of more rights-led and “fused” legislation;*

- c) ***Tracking the implementation of the reforms in and associated with this Bill, including the provision of data;***
- d) ***Providing advice and support to service users, their families and carers on their rights and how to navigate complaints processes; working with NHS bodies, the Care Quality Commission and Parliamentary and Health Service Ombudsman to promote best practice in handling complaints.***

We see the role of the Commissioner being primarily to act as a watchdog to oversee the direction of travel for the key reforms of the MHA, cognisant of the associated risks we highlight in this report relating to funding, implementation and unintended consequences. In addition, they would monitor outcomes and cultural changes which we hope will result from these

reforms. We recommend further functions for this role in Chapter 3 around inequalities and data.

Principles

33. The Independent Review's report identified four core principles ("the Principles") to its work and structured its recommendations around them:

- Choice and autonomy—ensuring service users' views and choices are respected;
- Least restriction—ensuring the Act's powers are used in the least restrictive way;
- Therapeutic Benefit—ensuring patients are supported to get better, so they can be discharged from the Act; and
- The Person as an Individual—ensuring patients are viewed and treated as rounded individuals.

The Review recommended that the Principles be embedded in the MHA through amending

legislation and that they should form part of an opening section - setting out the purpose and principles behind decision-making under the MHA. Sir Mark Headley, one of the Review Vice-Chairs, told us:

Part of the role of the statute is not to produce culture change but to encourage, support and consolidate it. The Mental Capacity Act opens with a set of principles. Speaking as a judge of the Court of Protection and as a law teacher, I think they are extremely helpful in focusing the mind every time somebody looks at the Act.

34. The proposition that the four Principles should be front and centre of the draft Bill was widely supported during our inquiry. Virtually every group of stakeholders we heard from was in favour, including professionals, care organisations, charities, academics, lawyers,

and groups representing service-users.

Professor Tim Kendall of NHS England summed up the views of many:

It would be right to have them in the Bill.

I am not underestimating how complex that might be because of legal changes that might need to be made to other parts of the Bill, but this is heralding the beginning of what we hope will be a major change in the way we deliver mental health care and care for people with learning disabilities and autism.

35. Some witnesses were not content for the Principles to simply be included in the draft Bill, they wanted them at the start. This was driven by the view that the structure and content of the MHA as it is currently written puts coercive power first, and acknowledges issues such as patient rights and choice, informal admission

and advocacy only much later. As Robert Lewis, from the Approved Mental Health Professionals Leads Network, put it:

At the moment, Section 1 says that mental disorder is what we say it is, Section 2 says that we will detain you, Section 3 says we will detain you, Section 4 says that we will hold you.

For me, that is the structure and the message it sends out. That is what influences all of us as professionals in how we approach these things. You start writing it the other way round with the person first and then you start to be able to put those things into the statute, the code of practice and other things.

36. The Government has so far resisted including the Principles in the draft Bill. It has argued that it would be complex to incorporate them into an existing piece of legislation and that these Principles are broader in nature,

and therefore harder to legislate for, than the statutory principles included at the start of the Mental Capacity Act. Instead, they propose to include them in the statutory Code of Practice required under Section 118 of the MHA, whilst stressing that they have been central to their thinking in drawing up the legislation. Justin Leslie, a mental health lawyer and former Parliamentary Counsel, broadly supported the Government's position, explaining:

The problem is that the Mental Health Act [...] was drafted a very long time ago in a very different environment and has been chopped and changed somewhat over the years. It would be a chop and change too far, in my view, just to put the principles in the Bill unless we are clear about what they are doing. You could have principles that form the basis of some sort of duty to have regard to them when making decisions under the Act.

How that flows through to every single decision that can be made under the Act is a complicated question.

37. The MHA already has a provision like the “have regard” provision that Mr Leslie referred to. Section 118 requires the Secretary of State to draw up a Code of Practice for those working under the MHA. It requires them to include “a statement of the principles which the Secretary of State thinks should inform decisions under this Act”. It also includes a list of matters that must be addressed under those principles, some of which are closely or directly related to the Principles outlined by the Independent Review, such as “respect for patients’ past and present wishes and feelings” and “minimising restrictions on liberty”. The Code may be modified by the Secretary of State under a negative statutory instrument procedure. This means that Members of either House of Parliament can object to a change in the Code,

but any debate or vote in response to such an objection is in the hands of the Government and not guaranteed.

38. The Government identified three advantages to placing the Independent Review's Principles in the Code of Practice rather than the Bill itself: removing the need to rewrite parts of the MHA, flexibility, and being able to consider the Principles against other factors, such as public protection in the case of Part III. On the other hand, NHS England, for example, argued that the process of amending the legislation would itself be beneficial, making the Government reconsider provisions of the Bill that conflict with the four Principles. The Centre for Mental Health noted that only being in the Code of Practice meant "not a lot of attention" was paid to the principles that are already required by the MHA.

39. The Independent Review's four Principles have been arrived at following an

extensive and consensual process lasting nearly half a decade. We want to see them in primary legislation, as opposed to a Code of Practice, so that they cannot simply be replaced or withdrawn by a future Secretary of State, to ensure they inform how the amended Act operates in practice, and to be a legal and symbolic driver for the cultural change that the draft Bill is trying to bring about.

40. *We recognise the Government's concerns about putting entirely new Principles into the Mental Health Act and are wary of making complex legislation yet more complex. We believe that there already exists a mechanism to put the Principles into the Act that meets those concerns. We recommend that Section 118 be replaced with a new Section, requiring the Secretary of State to draw up the Code of Practice having regard to and including the Principles set out in the Independent Review: choice*

and autonomy, least restriction, therapeutic benefit and the person as an individual.

The new Section should also specify that the Principles should inform decisions taken under the Act, mirroring the current wording in Section 118. This would ensure that the Principles endure, inform the operation of the amended Act and would require the Government to ensure they are reflected in the practical guidance given to professionals on all aspects of how the Act operates in practice.

41. We recommend that the replacement for Section 118 be placed at the beginning of the amended Act. This would reflect the central role of the Principles and Code of Practice in the operation of the Mental Health Act in practice. It would make the legislation more accessible and better tell the story of what the amended Act is trying to achieve. Placing principles relating to patient choice and least restriction in the legislation before

the powers to detain is logical and would send a message to help drive that cultural change ahead of more fundamental reform.

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3 Racial Inequalities

Disproportionate detention rates

42. According to NHS statistics from 2021–2022, ‘black or black British’ people are four times more likely than people from ‘any white background’ to be detained under the Mental Health Act (MHA), and over eleven times more likely to be given a Community Treatment Order (CTO). Some minorities are also more likely to spend longer in detention, experience multiple detentions, and be detained through contact with emergency departments or the criminal justice system.

43. One of the primary aims of the Independent Review was to consider the reasons for the disproportionate number of black and ethnic minority people being detained under the MHA, and to make recommendations to address this. It made several recommendations which span over many sections of the report, stating that these “represent a shift in tackling racial

inequalities by accepting that the structure of existing systems needs to change gradually to improve overall quality of services". Similarly, in our report, many of our recommendations for tackling racial inequalities sit within wider changes in the draft Bill and as such are addressed in those relevant sections. For example, we heard that advance choice documents (ACDs) would be a crucial measure in addressing inequality "to empower service users and patients when they are at their most vulnerable, to help address the power imbalance," and we address these in Chapter 8. In this chapter we discuss some further provisions which apply to the issue of inequalities in the application of the MHA.

The role of the legislation

44. The Government told us that the draft Bill addresses racial inequalities by "empowering people, and the advocates and Nominated Persons that represent them". They emphasised

that, alongside the Bill, a wide programme of non-legislative work will support the reduction of racial inequalities in the use of the MHA. This includes culturally appropriate advocacy pilots, rolling-out the Patient and Carer Race Equality Framework (PCREF) in the NHS, and delivering on several NHS strategies; including the NHS Advancing Mental Health Equalities Strategy, the Workforce Race Equality Standard, and the NHS Long Term Plan.

45. Many of the proposals to improve advocacy and patient choice have been widely welcomed. However we heard agreement that tackling disparities in the use of the MHA requires wider reforms to mental health and social care systems, not to mention changes to societal attitudes, and therefore legislation is only one part of the solution. As we heard from Professor Stephani Hatch from King's College London:

For many of us, racism and discrimination experiences have a life

course narrative, one that we experience first on going into the educational system and then right across social institutions.

46. The Independent Review team told us how they found it difficult to recommend legislative changes which would directly impact racial discrimination, especially where this legislation already exists. Steven Gilbert, one of the Vice Chairs, told us:

[...] why we did not just write, “Don’t be racist”. That is effectively what people wanted us to write, but you already have that in law. You already have the Equality Act. You already have the public sector equality duty. It could not be clearer. What is quite concerning is that in the time after the review I see lots of different professionals from lots of different areas, and they all have duties under the public sector equality duty, but a lot of them do not know what they are.

47. Similarly, Maurice Mcleod from Race on the Agenda said that the draft Bill had to be stronger, but that it alone could not address disproportionality:

We could do a brilliant job; I could write the Mental Health Act and make it exactly what an anti-racist might want it to be, but it still would not have all the tricks it needs because of the way it interacts with social care, housing, the criminal justice system and all the other elements of our society that still have a problem.

48. We heard from Dr Jacqui Dyer how, as a carer, she did not see any service provision which understood the individual needs of her family members, with two of her siblings dying at an early age:

I can clearly identify a system that has failed to look at them as a whole person, without the services in place to look

after them... For me, the urgency of getting this right is palpable, because that has been my lived experience. It has impacted on my own mental health, because of my anxiety about whether mental health service provision will support my other sibling to live a long life or whether she will also die early. That is partly to do with the mental health service provision not treating the person as a whole person—their mental health and their physical health issues.

49. Several recommendations were made throughout the evidence about how the draft Bill could be strengthened to address these structural and systemic issues. We heard particularly strong arguments for the use of ACDs and the provision of culturally appropriate advocacy in reducing inequalities in the use of the MHA. For example, three academics from the Institute of Psychiatry, Psychology, and Neuroscience at Kings College London told us

how ACDs are an “effective” way to advance mental health equality in the NHS, citing their research which “found economic benefit for services having Joint Crisis Plans (a form of ACD), especially in black and ethnic minority groups”. Dr Lucy Stephenson, one of the researchers, told us how their participants in the study were “very clear that advance decision-making is even more important for people from black communities because of their experience of trauma, increased disempowerment and increased discrimination”. These issues are discussed further in Chapter 8 and Chapter 10, respectively. In this chapter we discuss: updating the guidance for the Code of Practice, mandating data collection, introducing the role of a “responsible person”, and limitations in the use of CTOs.

Principle of racial equality

50. We heard from several organisations that, whilst it is difficult to legislate for unconscious

bias, or for clinicians to consider the experience of minority groups, the Code of Practice may guide those using the MHA to consider these factors—that “anti-racism be enshrined in the Act as a guiding principle”. Dr Nahed Arafat, a research student at the School of Languages and Culture, University of Sheffield, told us how service users come to her saying that “Nobody is caring about our religious or cultural beliefs”:

If they are able to express this, and if it is taken into consideration, that would be really good, but we are far away from this. Even in asking patients about these issues, up until now a lot of clinicians or health and social care professionals are unable to put the questions right to people.

51. Section 118 of the MHA includes a list of matters that the Secretary of State should ensure are respected, which currently includes diversity of religion, culture, and sexual

orientation. These were included in line with the Equality Act 2006. However, “race” (including colour, nationality, or ethnic or national origin) was not included, nor has the provision been updated to reflect the Equality Act 2010.

Data collection and publication

52. We heard about a lack of high-quality and consistent data on ethnicity and the use of the MHA, and how a standardised approach is needed. The Independent Review similarly commented on the “striking” lack of ethnicity data, which they felt “severely limits our ability to understand the wider experiences of many minority communities, particularly in cases where individuals identify with two or more ‘ethnic categories’”. They recommended that the Government should improve data collection and analysis of ethnicity and the use of the Act.

53. Data is mainly collected via the Mental Health Services Dataset (MHSDS), which uses operational data from service providers.

It is mandatory for NHS services, but not independent services, to submit data every month. Despite this, there is incomplete data from both NHS and independent services, with no sanctions against services who do not report their data, leading to issues with standardisation and reporting local breakdowns. We heard about an example of such an issue from a service user in our roundtable, they had been transferred five times between hospitals and each transfer was treated as a new admission under the MHA. This is one example of the issues that analysts have to account for when analysing NHS data. We heard that mandating data collection would mean the Government can focus on improving data linkage across health and social care services, which we heard would drive better understanding of inequalities beyond the MHA.

Responsible person

54. Finally, we heard the case for introducing the role of a ‘responsible person’ who would be responsible for monitoring and reporting on ethnic inequalities in their organisation, as seen in the Mental Health Units (Use of Force) Act 2018 for the use of restraint. This would ensure transparency and clear responsibility in monitoring inequalities “on a local level”, which could then contribute to understanding how to drive down inequalities across every trust.

55. The Independent Review considered the development and implementation of the PCREF framework to be their primary recommendation in reducing ethnic inequalities. Dr Jacqui Dyer, who leads the PCREF work nationally, commented that the framework is co-produced, built around leadership and the collection of data. We heard that this responsible person could be a “legal underpinning of the PCREF”.

Maurice Mcleod said it was crucial that there was clear responsibility for implementing change:

[...] a responsible person, someone whose specific role it is to draw up and implement plans to reduce racial inequality, similar to the role that has been introduced under Seni's law. It is really important for someone to own that task on a local level. Otherwise, we find that responsibility for doing this work gets passed from pillar to post, it is not really anyone's job, and it falls through the cracks.

56. The Independent Review was established to address racial and ethnic inequalities in the application of the Mental Health Act. Five years on these have not improved and, on some key metrics, are getting rapidly worse. This is a collective

failure that is unacceptable and inexcusable. The draft Bill must be stronger in how it tackles racial disparity.

57. The principles that the Secretary of State is required to draw up under Section 118 of the Mental Health Act that “inform” decisions under the Act do not explicitly include the need to respect racial equality. Whether or not they accept our earlier recommendation about re-writing Section 118, the Government should amend it so that the list of matters that the Secretary of State must address in the Code of Practice includes respect for racial equality.

58. Improving data collection will be an important part of reducing inequalities, but it cannot be an excuse for a lack of urgent and comprehensive action. There should be a responsible person for each health organisation whose role will be to collect and monitor data on the number,

cause, and duration of detentions under the MHA broken down by ethnicity and other demographic information. The Secretary of State must ensure that these statistics are published at the end of each year.

59. The Responsible Person should also oversee workforce training and policies designed to address bias and discrimination in decision making in the operation of the Mental Health Act on the basis of protected characteristics, including the implementation of the Patient and Carer Race Equality Framework (PCREF).

60. We recommend that one of the roles of the Commissioner proposed in Chapter 2 will be to be a national figure overseeing, standardising, and promoting the work of the ‘Responsible People’ proposed above and already in the Mental Health (Use of Force) Act. They should also work with NHS and independent services, the Care Quality

Commission, Equality and Human Rights Commission and the Office of the National Data Guardian, to produce proposals aimed at reducing inequalities in, and improving data on, the provision of services and use of powers under the Mental Health Act.

61. The Government should work with NHS England to produce an implementation plan for the NHS's non-legislative programmes to address inequalities in mental health care with clear milestones and reporting against them. Examples of milestones might include appointment of 'Responsible People', take up and implementation of the Patient and Carer Race Equality Framework, increased awareness of the public sector equality duty, reductions in disproportionate detention rates, improved diversity in the workforce and access to culturally appropriate advocacy, which is discussed later in this report.

Community Treatment Orders

62. A Community Treatment Order (CTO) allows a patient to be discharged into the community under treatment conditions imposed on them by their clinician. If they do not comply with these conditions, the patient may be recalled to hospital. They were introduced in the Mental Health Act 2007 and were intended to reduce re-admission and improve public safety for a small number of patients. When they were introduced, the post-legislative committee reported that 10% of Section 3 admissions should be placed on a CTO. However, about 5,000 people are currently on a CTO, compared to the 455 that the post-legislative scrutiny committee might have expected (there were 4,553 patients on a Section 3 admission in 2021–22). Furthermore, CTOs are disproportionately used for black and ethnic minority patients, with CTO use being around

eleven times higher for ‘black or black British’ individuals, compared to individuals from ‘any white background’.

63. The Independent Review acknowledged the controversy around the use of CTOs, with many calling for their abolition. Their focus groups included a quote from an Approved Mental Health Professional (AMHP) describing how CTOs are disproportionately used on black men:

I had a young 15 year old Black Caribbean male, the first presentation [...] He had a section 2. Then he had a 3 and then [...] the next step “we’ll consider a CTO”. What for? What have you actually tried in the community? You haven’t discharged him. You haven’t even tried him on leave, escorted or unescorted leave. You haven’t tried anything [...] You’re just thinking of him as a scary Black guy who just [sic] you just need to control.

The Review made recommendations which were intended to halve the use of CTOs, saying that if within five years there had not been either a reduction in the use of CTOs, or an increase in their effectiveness, then their use should be reviewed altogether. The draft Bill therefore makes amendments to the provision and oversight of CTOs, based on these recommendations. However, the draft Bill does not commit to a timeline for their potential abolition, even if there is no reduction in their use. Sir Simon Wessely felt “slightly disappointed” that the Independent Review’s recommendations had been “watered down”.

64. We heard several concerns that the measures in the draft Bill would not be sufficient in reducing the number of black people being subjected to CTOs, and several witnesses told us that CTOs should be abolished from the MHA altogether. Maurice Mcleod said:

our desire would be that they are removed completely. As I said, once you have that level of subjectivity and power, we fear that it is almost always going to be used in a disproportionate or discriminatory way, because we have not yet got to a place where those biases are not in society. The fact that they exist in society means that, when you give those powers to individuals, they are more likely to act in a biased way, because that is, sadly, ingrained in us.

65. We heard that that there is significant research that shows CTOs do not reduce re-admission to hospital and that CTOs “represent the starkest racial disparity in the use of the Act”. Additionally, when the Independent Review made their recommendations in 2018, the use of CTOs for ‘black and black British’ patients was eight times higher than for patients from

‘any white background’ compared to eleven times higher today. Their disproportionate use is clearly increasing, rather than decreasing.

66. Service users during our roundtable discussion told us that they felt CTOs were an easier way for clinicians to manage discharge, but that this was just a way to pass on responsibility. One service user told us during our roundtable that he knew someone who felt so restricted under a CTO that he tried to take his own life. Another, via survey response, told us how CTOs have caused “untold damage to person centred, collaborative care”.

67. Nonetheless, the Independent Review’s decision to not recommend immediate abolition was in part because of the perception that CTOs represented the least restrictive option for unrestricted forensic patients (where a hospital order is given by the court), who are not eligible for conditional discharge. During our visit to Lambeth Hospital, we similarly heard forensic

clinicians argue that CTOs were a crucial part of “step-down” care, moving unrestricted patients under Part III of the MHA from secure accommodation into the community. There are significantly lower numbers of Part III (forensic) patients subject to CTOs, compared to Part II (civil) patients, perhaps more in line with the numbers initially proposed. For example, between 2021–22 there were 5,552 people subject to a CTO, with 4,388 (79%) being under Part II of the MHA and 149 (2.7%) being under Part III of the MHA.

68. *The evidence shows that Community Treatment Orders (CTOs) are being used more than intended and, in many cases, as a more restrictive alternative to discharge. There is not enough evidence to demonstrate benefit for the use of CTOs for Part II patients to justify their continued use, especially as they are used disproportionately for black and ethnic*

minority patients. We recommend that CTOs are abolished for patients under Part II of the Mental Health Act.

69. We have received some evidence that suggests unrestricted Part III patients may benefit from CTOs. However, that evidence is inconclusive, so we recommend that the Government should amend the draft Bill to include a statutory review of CTOs for Part III patients, to report within three years of Royal Assent.

70. We also recommend that the Bill contains a provision that abolishes CTOs for Part III patients six months after the time for the statutory review recommended above expires (or earlier with the approval of both Houses of Parliament). This would give the Government time to introduce legislation to stop the abolition of CTOs for Part III patients if the statutory review demonstrated convincingly that they had value and were

now being used in a non-discriminatory way. If that were not the case, they would be abolished automatically without need for further legislation.

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4 Resourcing and Implementation

Resourcing implications of the draft Bill

71. As has been set out in previous chapters, the draft Bill contains a complex set of proposals which impact upon multiple stakeholders in the provision of mental health services. As the Government acknowledges in the Impact Assessment, these will require a sustained period of direct investment in services and an expansion in the workforce. When announcing the publication of the draft Bill in the House of Commons, the then Secretary of State, Rt Hon Sajid Javid MP, acknowledged the importance of the workforce to the implementation of the draft Bill, expressing confidence that demand could be met.

72. Upon publication of the draft Bill, Sir Simon Wessely noted in an article that without adequate resourcing the changes proposed were unlikely to be effective:

The amendments [in the draft Bill] propose tightening the criteria for detention, a greater emphasis on stays in hospital being purposive, and a far greater statutory ability for patients to have a say as to what treatments they receive. All of these would go a significant way towards achieving the goals that we set ourselves. But, and it is a big but, legislation alone cannot change very much, no matter how well intentioned and drafted—providing adequate alternatives to coercion requires equally adequate resourcing.

73. Resourcing and implementation were two of the most commonly raised issues in the evidence we received. Respondents to our survey were overwhelmingly of the view that greater resourcing would be needed to support the draft Bill's implementation and a significant majority felt there were not sufficient routes to receive care other than detention at present.

Many stakeholders expressed concern as to whether sufficient resources would be in place to support the provisions. For example, the NHS Confederation noted that “many of the recommendations rely on additional resources and staffing capacity and without significant additional resources for the NHS, social care and the Tribunal Service, the proposals will not be successfully implemented”.

Existing resourcing provisions and impact of proposed changes

74. We heard repeatedly that the proposals in the draft Bill, if implemented, would apply to services that are already under considerable pressure from the interrelated issues of growing levels of demand, workforce and resourcing challenges, and pressures following the end of restrictions in place during the Covid pandemic. Dr Gareth Owen, representing the Royal College of Psychiatrists, noted the longstanding challenges surrounding funding for the provision

of mental health services: “Mental health services have been under intense pressure for many years. It is only going to get worse as we understand the full impact of the pandemic on the services”. Similar concerns were raised by the British Association of Social Workers (BASW) in their written evidence that “From the perspective of the social work workforce, there are already insufficient staff to deal with current challenges in the form of both increasing demand and the existing backlog of work which has been aggravated by the effects of the pandemic”.

75. We have received evidence saying that workforce shortages can be particularly acute in mental health services compared to other health services, and we heard from the Royal College of Nursing their concerns about ongoing shortfalls in filling existing vacancies, workforce retention and recruitment. We were told similar challenges exist in the recruitment and retention of Approved Mental Health Professionals

(AMHPs), where evidence provided by the BASW suggested up to one third of the current AMHP workforce are approaching retirement age.

76. In May 2022, the Government published an Impact Assessment, setting out the resourcing implications and the timetable of the implementation of the proposals. This included objectives to be implemented across multiple stakeholders including the police, health services and the justice system. A consistent theme from witnesses representing service providers and professionals delivering these proposals was that they do not think the Impact Assessment is a realistic projection of the resourcing and workforce implications of the draft Bill.

77. NHS England told us that although they were confident that the provisions would be implemented once the bill was passed, there were areas where detailed planning had yet to

be completed. We heard that whilst discussions are underway between the Department for Health and Social Care, Health Education England and NHS England concerning the full workforce implications, these have not yet concluded, implying that the workforce and resourcing implications of the draft Bill are not yet fully understood.

78. The Government's Impact Assessment acknowledges uncertainties around the full implementation and resourcing requirements, and said there were two main groups of uncertainties:

- the magnitude of the future number of people detained or under CTOs, either in response to wider trends, or the impact of the proposed reforms;
- how much additional time from the health and social care workforce will be required to deliver the additional

safeguards and how much current work will need to be re-adjusted in line with the reforms.

79. As set out in the following sub-sections, we heard particular concerns about proposals for improved community services, and the increased workload for Second Opinion Appointed Doctors and tribunals.

Further provision of community care

80. One of the principle aims of the reforms proposed in the draft Bill is to reduce the number of detentions under the Mental Health Act. An essential aspect of delivering this objective is to have adequately resourced community care provisions in place. In oral evidence to the Committee, Rethink forecasted significant resourcing implications arising from this as:

If you are changing the detention criteria, meaning that fewer people

will be detained but they are at a crisis point, that makes it even more essential that community mental healthcare is provided. That will be an increased demand over and above what was set out in the long-term plan and the funding that was set out for that.

81. Whilst fewer people being detained would reduce resource requirements on hospitals, the Association of Directors of Adult Social Services (ADASS), in a joint submission with the Local Government Association, expressed concern that the costs of discharge for:

[...] many of the remaining inpatients, particularly those with longer lengths of stay, is likely to exceed the levels of funding released by reduced inpatient use. Additional funding will be required to ensure that the impact of the creation of significant deficits on local health and adult social care system budgets does

not begin to act as a barrier to prompt and successful discharge of those with higher levels of need.

82. Discharging patients from hospital into the community can be a complex and challenging process. We heard during our visit to Lambeth Hospital that there can be significant delays to discharging patients due to the lack of available suitable accommodation or disagreement amongst local authorities as to where funding may be provided to support this. Care England said: “for community care to work, commissioners, regulators and the wider multi-disciplinary team, will need to support and enable a stable, confident staff group to acquire new skills where needed”. We also heard in responses to our survey that mental health care and particularly community care services would need considerable investment to ensure that the reforms will be effective.

83. The Government's Impact Assessment published alongside the draft Bill acknowledged the additional costs that will result from the draft Bill but also noted forecasted savings from fewer people being detained. The Impact Assessment did go on to acknowledge that the absence of quantitative evidence in some areas had a potential impact on the accuracy of the forecasts:

The benefits associated with the proposed policy... are likely to be significant. However, due to the absence of quantitative evidence for the impacts on patients ... we were only able to monetise cost savings from a reduction in detentions following ACDs and new criteria for people with LDA, from reduction in CTOs leading to less healthcare and automatic referrals costs, and from tribunal cancellation fees in the Justice system.

84. There are particular resourcing implications arising out of the provisions in the draft Bill for people with learning disabilities and autistic people, as the draft Bill removes learning disabilities and autism as conditions for which an individual can be detained for treatment. These proposals are discussed in greater detail in Chapter 6.

Provision of Second Opinion Appointed Doctors

85. We also note concerns surrounding adequate resourcing for the likely increased provision of Second Opinion Appointed Doctors (SOADs). These include earlier access to SOADs (reduced from 3 to 2 months), a requirement for SOADs to authorise detained patients being administered psychiatric drugs without consent, and the requirement for SOAD certification in the event of urgent electro-convulsive therapy (ECT) procedures to save life if a patient has made an advance decision to

refuse such treatment. The Independent Review noted the likely increase in workload for SOADs, and included as one of its recommendations:

The Government and the CQC should consider ways to resource the likely increase in SOAD reviews looking at how the model of SOADs can evolve.

86. The Care Quality Commission, who are responsible for the appointment of SOADs and manage the SOAD service, noted in their written evidence concerns around the proposed resourcing of these from current provisions and the likely funding requirements. Whilst supporting the ambition to increase protections for patients under urgent ECT procedures, they have concerns about the impact of this proposal:

We are concerned that the criteria to override a capacitous patient decision must be robust and sufficiently detailed in the Act or Code of Practice to enable thorough scrutiny by whichever authority

is assigned. This new service would need significant government funding and support, including for an out-of-hours 24-hour SOAD service which CQC would be required to set up and manage. As predicted volumes of use of this service are unknown, and because we predict that implementation would be resource intensive, it's questionable whether this proposal is proportionate to its intended aim, namely enhancing protection for patients. Currently, the SOAD service is not sufficiently funded by government for the routine service. We are in discussion with the Department of Health and Social Care (DHSC) about how our concerns about the proposal, as well as the needs of patients, can be addressed.

87. They provided further details on their forecasting for additional provision of SOADs following their oral evidence, and have written to

us saying that their workforce modelling showed 100 more SOADs were needed now, with that figure increasing to over 400 by 2027–28 and almost 500 by 2041–42. The Government's Impact Assessment forecasts the required numbers for those years to be 80 in 2027–28 and 94 by 2041–42. Whilst the CQC say they are engaged in discussions with the Department for Health and Social Care concerning the likely increased workload on SOADs (as recommended by the Independent Review), there is still concern that this extra resource will not be in place.

Tribunals

88. A further area in the draft Bill which we have heard would have significant resourcing implications is the anticipated additional workload for tribunals. These proposals are covered in more detail in Chapter 8. We heard evidence on behalf of the Royal College of

Psychiatrists that in the College's view the proposal for the increased frequency of referral to tribunals:

[...] can't be absorbed into the existing workforce. The College commissioned some modelling on this. It looks as if, even on fairly modest assumptions, there would need to be 494 extra psychiatrists to be able to effect the proposals. They don't look deliverable at the moment.

89. These concerns have been reiterated by other stakeholders including NHS Providers and the Care Quality Commission. In oral evidence to the Committee, we heard that an important part of the implementation period must be a full acknowledgement of the additional impact these proposals will have on clinicians. The Government has recognised the training and workforce lead in times, and these are reflected

in the Impact Assessment which forecasts some of the provisions around tribunals not being fully implemented until 2030–31.

Future commitments to funding

90. The NHS Ten Year Plan, published in 2019, contained a commitment for increases in funding available across child and adult mental health services. The Minister for Mental Health in her evidence to the Committee said that the Government was committed to providing additional resources to support care for patients with mental health problems at a much earlier stage, so that:

[...] patients get treatment where they want it, when they need it, and they have a voice in that. That means investing in resources across the board outside of the legislation. That is why £2.3 billion a year of additional funding is going in from next year, to resource financially the work we are doing.

91. The Chancellor of the Exchequer's Autumn Statement on 17 November 2022 included a commitment for additional funding for freeing up capacity in hospital beds. He said:

I also want the social care system to help free up some of the 13,500 hospital beds that are occupied by those who should be at home, so I have decided to allocate for adult social care additional grant funding of £1 billion next year and £1.7 billion the year after.

It has yet to be announced whether any of this money will support freeing up mental health beds.

92. The Government has committed to an early review of the impact of the reforms in the draft Bill:

Our aim is to assess the impact of our reforms in the round, both legislative and non-legislative. To support this, we intend to commission an independent

evaluation of the first phase of our reforms, as set out in our Impact Assessment, through the National Institute for Health and Care Research. This would provide rigorous academic evaluation of the impact of both legislative and non-legislative reforms that take effect in the first phase of implementation.

93. We recognise that the fiscal environment in which the Impact Assessment which accompanied the draft Bill was prepared has evolved, even during the existence of this Committee. There may be further changes to public spending, and the impact of the changes proposed in the draft legislation will take time to materialise, particularly when the timetable for implementation contains some provisions which will not be fully implemented until 2030–31. In addition to the commitment to review the implementation of the first phase of reforms, the Minister has acknowledged that the funding

to support implementation of the draft Bill would be reviewed and may change during the implementation period:

[...] the plan for the Bill is not to get it all in place in this spending review timeframe. We are being up front about that. We will have to look at further spending reviews as the Act is rolled out.

94. Despite the concerns expressed by witnesses concerning workforce and resourcing, we recognise that the benefits that would arise from the reforms are significant. Sir Simon, in his oral evidence to the Committee, whilst recognising the importance of challenges around resourcing and implementation, strongly supported proceeding with the reforms in the draft Bill even if pressures on existing services continued and no further resources than already forecasted were provided.

95. Successful implementation of this legislation should result in a transformational impact on mental health services, reducing pressures on inpatient services. However to achieve this it will need adequate funding and workforce provision. We have heard scepticism about the existing implementation plans in our evidence. Without adequate resourcing, the reforms may divert resources from services that are already under intense pressure or prove to be ineffective.

96. *We recommend that the introduction of the final Bill should be accompanied by a revised impact assessment to take account of changes in the workforce and the economy since the original was published. It should also be explicit about the extent of interdependencies with other Government programmes and policies.*

97. The Government should publish a comprehensive implementation and workforce plan alongside the Bill. It should contain clear actions and key milestones detailing the implementation of the Bill and how they link to milestones in the implementation of the 10 Year Plan and other relevant Government policies. These should include milestones on workforce development, training, advocacy and community care capacity, as well as on numbers of detentions, length of stay and reducing racial and ethnic inequality. There should be a statutory duty to report annually to Parliament on the progress against these milestones during the implementation period.

5 Detention Criteria

Background

98. At the centre of the Independent Review's work, and the draft Bill, are the principles that care should be provided in the least restrictive way possible and only through detention where there is therapeutic benefit. To support this, the Independent Review recommended changes to the grounds on which someone may be detained for assessment or treatment under the Mental Health Act (MHA). Consequently, in the White Paper, the Government said it would:

[...] revise, strengthen and clarify the detention criteria to ensure that, in the future, detention only takes place when it is absolutely appropriate. We will also introduce requirements around how and when the new detention criteria should be applied, to ensure that—people are only detained when there

is a clear justification for doing so and that they are discharged as soon as that justification ceases to be relevant.

99. The draft Bill makes changes to the criteria in respect of Section 2 (Admission for assessment), Section 3 (Admission for Treatment) along with Section 5 (Detention for six hours pending application for admission) and Section 20 (Renewal of authority for detention of patient detained in pursuance of application for admission for treatment etc). The key changes are to:

- Replace the existing criterion that required a broad assessment that detention was necessary for the health and safety of the patient or others, or was appropriate given the nature and degree of the mental disorder. The new criterion require an assessment that serious harm may be caused to the health and safety of the patient or others unless the patient is

detained for assessment and treated, and in certain contexts require consideration of the nature, degree and likelihood of the harm, and how soon it would occur.

- Replacing the existing definition of “appropriate treatment” with treatment that has “a reasonable prospect of alleviating, or preventing the worsening of, the disorder or one or more of its symptoms or manifestations”.

The first change applies to those detained under the sections outlined earlier in this paragraph only. The second applies throughout the Act, including to Part III patients—those involved in criminal proceedings or under sentence.

100. The other major change is to the definition of ‘mental disorder’, which would mean learning disability or autism would not be reasons for detention under Section 3. We discuss that change in the next Chapter.

The Independent Review's recommendations

101. As set out above, changes to the detention criteria to embody “least restriction” and “therapeutic benefit” were recommended by the Independent Review. The Government’s proposals are broadly in line with those recommendations, though the Independent Review’s proposed wording of “substantial likelihood of significant harm” to the patient or another has been defined in more detail as “serious harm may be caused” to the patient or another, considering “the nature, degree and likelihood of the harm, and how soon it would occur”.

102. The Independent Review argued that the criteria set out in the MHA were too vague, too focused on risk and promoted a risk averse culture. They argued that the criteria should focus on potential outcomes, rather than risk in the abstract, and that:

Because ‘health’ encompasses ‘mental health’, a person can be detained under the Act to avoid any deterioration in their mental health or relapse even if there is no other risk. This may have allowed professionals to become increasingly risk averse; to become too quick to use ‘risk’ as a catch-all justification when they are afraid of consequences that may never happen, indeed probably won’t happen.

103. The Review team saw their new criteria as driven by the views of service users and part of a larger package, intended to encourage professionals to view patients as people rather than “risk entities”, requiring them to identify and record the specific potential harm and how detention would prevent or mitigate it. The new criteria were identified as particularly important in tackling inequality by Dr Arun Chopra, who led the topic group on the detention criteria:

It is not just anecdote that people from a BME background are considered to be riskier. In Scotland, my organisation published data last year showing that people who come from black or mixed race groups in Scotland are more likely to be seen as posing a greater risk to other people than other ethnic groups. So strengthening the criteria adds transparency for people to be able to challenge the rates.

104. Steven Gilbert, one of the Vice Chairs of the Independent Review and someone who has experienced mental health crisis, agreed.

What we are doing with the detention criteria [...] is really about trying to say that you cannot view people as scary and that that is no reason to detain them. Do they have a genuine need that can only be met in hospital?

The changes in practice

105. The principle of a change in detention criteria towards more accountability and the more detailed requirement for medical benefit was welcomed by some of our witnesses. At the same time, there were a variety of views on what impact, if any, the changes might have, and whether the wording in the draft Bill was the right one. Dr Lucy Series, Lecturer at the School of Policy Studies, University of Bristol, told us it is difficult to anticipate exactly how any change to the criteria might play out in clinical decision-making and it is likely to be interpreted in different ways by different people. This uncertainty may explain the variety of views we heard.

106. Some saw the changes as relatively minor compared to the changes required. Despite the importance the Independent Review placed on the changes as a way of tackling inequalities, it was telling that witnesses

who focused on inequality were much more concerned with cultural and workforce change, data and concrete proposals around patient choice and rights.

107. Many of our professional witnesses saw the revised criteria as reflecting, or being lower than, current practice for the threshold for admission. They told us a large part of this was due to the acute pressures mental health facilities were under, meaning that people were only being admitted when they had “catastrophically deteriorated”. They were sceptical that the changes would have much impact in practice until that changed.

Raising the bar?

108. These resource pressures and the difficulty of finding care for those who need it was at the centre of the biggest concern we heard about the changes in detention criteria—that it might make it harder to admit people

who needed care. Dr Chloe Beale, a Liaison Psychiatrist and suicide lead for her Trust, told us:

One of the concerns that I have about the tightened criteria [...] is [...] the possibility that people will have to deteriorate quite a long way before meeting detention criteria, particularly people who might be overlooked already because of certain stigmas; people who might be seen as a bit of a waste of time; people who already are not wanted in hospitals.

This particular concern arose out of cases where the concept of “capacity” had been misused to justify denying individuals care that they had sought on a voluntary basis. These cases were concerning in their own right and some witnesses felt the revised detention criteria might be used in a similar way. The treatment of people with eating disorders and

personality disorders were of particular concern, with Dr Beale seeing them as groups of people who might be turned away “citing legalese essentially”.

109. This was a concern that we also heard from some service users, families and carers, through written evidence, our survey and roundtable. For example, the relative of one person who had died after being turned away from hospital told us they were “very alarmed” at the prospect of it being harder to detain people under the MHA. Dr Mark Buchanan from the Royal College of Emergency Medicine said patients already came into A&E with the expectation that they would simply be sent home, without getting help. He said this was down to a lack of hospital capacity, but it would be “dangerous” if the perception was strengthened such that those who needed help would not seek it.

110. Sir Simon Wessely wrote to us after our hearing with him to address this specific concern, reemphasising that the aim was to ensure transparency and accountability and to address the perceived misapplication of the current criteria:

Our starting position is that we do not think care should ever be contingent upon detention, so changes to detention criteria should not impact upon the duties upon the State to secure adequate care for those in need of it. Our approach was, however, predicated upon our perception (informed by our engagement with stakeholders) that the current detention criteria can be misapplied to allow detention in circumstances where there is, in fact, no sensible therapeutic benefit that can be offered and/or without requiring a proper evaluation of the risks that the person is actually at or may pose.

Tightening up the criteria will allow greater transparency and accountability; we would be troubled—and surprised—if it meant that those who actually require admission in circumstances of confinement were denied it.

Definitions and guidance

111. Key to whether the risks identified in the previous sub-section materialise will be two things. First, and most importantly in the view of most of our witnesses, the resourcing of community alternatives to admission as discussed in the previous Chapter. Secondly, the guidance and interpretation placed on the key terms in the new detention criteria, which we address here.

112. “Serious harm” was felt among many of our witnesses to be a term requiring better definition either in the draft Bill or in the Code of Practice. Much of this was to address the issue raised in the previous subsection—would it prohibit

detention in all but the worst situations of crisis? Professionals also wanted to understand whether “harm” would include harm arising from health neglect or health deterioration, or financial or family breakdown and take into account circumstances such as housing.

113. We took up the perceived need for greater guidance on “serious harm” with the Minister. She argued that it would be inappropriate to mandate what she described as a clinical decision in the Bill itself, but on being pressed said that there would be a “non-exhaustive” list of potential harms in the Code of Practice.

114. A related issue that some professionals felt to be in need of clarification was the requirement to consider “how soon” harm might occur. Some witnesses strongly welcomed this consideration, seeing it as a protection against the long-term detention of individuals on the basis of a historic risk or harm. Others questioned, or called for more guidance on, how professionals would

be able to make what the Royal College of Psychiatrists called “pseudo-exact probabilities/predictions” on individual cases. Finally, some were concerned that it might conflict with therapeutic benefit, dissuading an earlier intervention that might have been shorter and more effective. As an example, a family member told us how they and their relative were very familiar with the early warning signs of her worsening psychosis. However, she was not admitted because the MHA assessment concluded the least restrictive option at that stage was for her to remain in the community. It was only after her symptoms had worsened considerably, including her throwing out all her belongings and the involvement of multiple emergency services, that she was admitted. The family felt strongly that the outcome would have been better, and traumatic experiences for her and them avoided, if she had been admitted earlier.

115. Although the concept of therapeutic benefit was widely welcomed, some suggestions were made to improve the definition of “appropriate treatment”. Some were concerned that it focused too much on the outcome of treatment, which is difficult to predict, instead of the purpose of treatment. A few witnesses wanted to see a definition that better reflected or ensured access to non-drug-based interventions. This has the potential to be particularly important for black and ethnic minority communities since, as Dr Jacqui Dyer, Director of Black Thrive, told us:

we know that black, Asian and minority ethnic communities do not get access to psychological therapies when they are an in-patient or have been detained under the Mental Health Act. The emphasis is likely to be on some forms of medication rather than a range of options that are bespoke and tailored to meet the needs of the whole person and treat them with dignity and respect.

116. Others were concerned that it might be used to deny care to those for whom improvement was seen as unlikely. The reference to alleviating “manifestations” of the illness in the criteria was also questioned as potentially vague and possibly leading to inappropriate long-term detention, though Justin Leslie, mental health lawyer and former Parliamentary Counsel, felt this was unlikely.

117. The Minister said that the Government was happy to look at the potential unintended consequences of the phrasing in the draft Bill as it stands. She clarified that the Government’s intention in putting the “how soon” criterion in the draft Bill was not to set out a required timescale or require “imminence”.

118. We reiterate the conclusion of our previous chapter that the changes in detention criteria, as with the draft Bill as a whole, need to be supported with

adequate and accessible community-based alternatives to detention if they are to be successful.

119. *We were disturbed by the evidence we received that the concept of “capacity” has been misused to deny treatment to very ill and potentially suicidal patients when they have voluntarily sought it. We recommend that the Government set out in the response to this Report what it, the CQC and NHS Trusts are doing and will do to prevent this practice.*

120. *We welcome the Government’s confirmation that there will be further guidance on applying the new detention criteria in the Code of Practice. We recommend that this particularly address the definition of “serious” harm and give guidance on how the “likelihood” of harm should be assessed. This should balance the need to ensure detention is a last resort*

with the potentially greater therapeutic benefits of an earlier intervention in some cases. It should be clear that the changes in criteria should not be used to deny care to those who need it and would benefit from it, including where serious harm would arise from a breakdown in personal circumstances, health neglect or deterioration.

121. We recommend that the consideration of “how soon” harm might occur should not be included in the draft Bill itself.

This was not in the Independent Review’s recommendation and would be better handled in the Code of Practice. Whilst we recognise what the Government is trying to achieve, it will be difficult for professionals to assess objectively. We are concerned that it might dissuade potentially beneficial and shorter interventions at an earlier stage that would be in keeping with the Principles. We recognise that some witnesses saw this

provision as tackling the very real issue of long-term detentions of questionable benefit, but believe that these are already, and more effectively, addressed under other provisions in the draft Bill, such as increased reviews by tribunal.

122. *We recommend that the Code of Practice also give guidance on how the definition of “appropriate treatment” should be interpreted in cases with a relatively low chance of improvement, or where resourcing means treatment may not be immediately available. It should also make clear that “appropriate treatment” includes non-drug-based treatment.*

Differences between Part II and Part III of the Mental Health Act

123. Part III of the MHA concerns those who are subject to a compulsory measure under the Act by the criminal courts, or who have been transferred to hospital from prison or another

type of custody, for example, an immigration removal centre. They are also termed ‘forensic patients’.

124. The draft Bill does not introduce the new ‘harm-based’ detention criterion for those under Part III of the MHA, nor remove autistic people or those with learning disabilities from the definition of ‘mental disorder’ under this Part. The Government argued that it would be “inappropriate to extend the new risk criteria for detention to Part III patients as risk in this context is a matter of discretion for the courts and, in the case of prison transfers, the Justice Secretary”. We have also heard that having a “lower bar” for detention in Part III supports the principle of least restriction, where the alternative is prison.

125. We have heard widespread concern that the increased differences in detention criteria between Part II and Part III that would result from the draft Bill may lead to unintended

consequences, such as patients being diverted into the criminal justice system or confusion for patients and clinicians when moving between the two. For example, NHS England told us how the difference in application between Parts II and III of the MHA “may lead to inappropriate ‘shunting’ between the MHA and the Mental Capacity Act, or the use of forensic sections of the MHA in cases that would currently have been managed under the civil sections”.

126. Working to two different standards has been labelled as ‘discriminatory’ against forensic patients. We heard strong challenges to the presumption that Part III patients are higher risk than Part II patients and that it is common for individuals to move between the two parts of the MHA. For example, we heard from Dr Smith that “74% of people who end up becoming forensic patients have been general adult patients for many years beforehand. As someone said earlier, these people will move from being a Part

II patient to being a Part III patient, and then move back to being, essentially, a Part II patient again”.

127. We have also heard this could be particularly problematic for black people, autistic people and people with learning disabilities. We heard the actions of black people in crisis are more often interpreted as criminal, rather than mental distress, compared to other ethnic groups. As such, a lower threshold in Part III may create a further disproportionate division in the way black people experience the MHA.

128. Similarly, we heard that removing learning disabilities and autism from Part II of the MHA, but not Part III, may lead to more people with learning disabilities or autistic people being detained via the criminal justice system, “particularly when they are presenting in that crisis situation, where they are a risk to other people”. Put starkly, the changes mean “autism is not a mental disorder within

the meaning of the MHA, yet it becomes one if an offence is committed". The Government said it made this decision following "extensive consultation with experts and key stakeholders" with their main reason being that "This approach ensures patients detained under Part III can be diverted from prison to hospital under the MHA to access the specialist support they need in a more therapeutic environment, where appropriate".

129. However, another view is that it would be strange and potentially problematic for it to be easier to get admission to in-patient facilities in prison than in the community. Further, the Government's argument that the alternative is prison is not always accurate. Dr Smith told us how there are "fewer difficulties with forensic beds than there are with general adult beds", meaning it can be "easier to get them in via the forensic route". They said that many people who are unwell present with challenging behaviour, and when they are deteriorating and need

mental health care “whether that challenging behaviour is counted as being criminal could well depend on whether we could get them in via the courts”.

130. ***At present the changes in the draft Bill mean it may be easier to be detained under Part III of the Mental Health Act, which deals with those who are in the criminal justice system, compared to Part II, which covers the rest of the population. We have heard convincing evidence that this is difficult to justify on the grounds of risk and that it could result in an increase in black people, autistic people, and people with learning disabilities being detained under Part III of the Act. This would be contrary to the aims of the Review and the draft Bill. We recommend that the changes in detention criteria should be consistent for individuals under either Part II or Part III of the MHA.***

6 Learning disabilities and Autism

Direction of travel

Background

131. It has been widely recognised, including by multiple witnesses in this inquiry, that mental health hospitals are not the right place for most people with learning disabilities and autistic people. In written and oral evidence we have heard repeatedly that autism and learning difficulties are not mental illnesses. This understanding is reflected in the Government's 2021 White Paper, 'Reforming the Mental Health Act' ('the White Paper'), which states that "both learning disability and autism are lifelong conditions, which cannot be removed through treatment".

132. Nonetheless, "too many" people with these conditions who present to services in a state of crisis are being detained in inpatient mental health facilities such as hospitals and

Assessment and Treatment Units (ATUs), as reported by the Care Quality Commission (CQC) in 2022. As of August 2022, the NHS Digital figures show that 1,970 people with learning disabilities or autistic people were in hospital in England. Of those in hospital at the end of the month, 1,115 (57%) have had a total length of stay of over 2 years. This includes 350 who have been in hospital for more than 10 years. As of October 2022, people with learning disabilities or autistic people have an average stay of 5.4 years. By comparison, the median length of stay under the Mental Health Act in 2020–2021 was 27 days. Currently, 93% of people with learning disabilities or autistic people in ATUs are detained under the MHA.

133. The use of compulsory detention for people with learning disabilities and autistic people has been identified as a human rights issue. In 2019 the Joint Committee on Human Rights concluded “the detention of individuals in the absence of individualised, therapeutic treatment risks violating an individual’s Article 5 (of the European Convention on Human Rights) right to liberty and security”. Simone Aspis from Inclusion London told us that disabled people are the only group of people that can be detained against their wishes, where they come under the MHA or Mental Capacity Act. She supported the 2017 view of the Committee of the United Nation Convention on the Rights of People with Disabilities (UNCRPD), which recommended, among other points, that the UK repeal all legislation providing for non-consensual involuntary, compulsory treatment and detention on the basis that it conflicts with Article 14, the Right to Liberty and security of the person.

134. We heard from numerous witnesses that treatment in inpatient mental health facilities can lead to worse outcomes for this group of patients. VoiceAbility told us that inpatient settings lead to increased distress as the person demonstrates traumatised behaviours in response to an inappropriate environment. This in turn results in “a vicious cycle of increasingly restrictive practice” and can lead to people being held in long-term isolation with little meaningful social contact. We also heard moving testimony from Alexis Quinn, a manager at the Restraint Reduction Network who was previously detained under the MHA in secure hospitals for over three years. She told us that inpatient mental health services were like a “sensory nightmare”:

Basically, when I get into the service and the door shuts and you are in an absolute sensory nightmare, that is very specific to autistic people. It is loud. It is chaotic. There are lots of lights. It is busy. It is moving all the time. There are

alarms going off. There are people all over the place. There are staff changing over. There are patients coming and going. That creates an overload. You can hold that overload for only so long without the ability to sensory modulate.

[...] I would then have a meltdown, and then the meltdown would be met with six to 10 men holding me down, injecting me in the bum with a sedative, usually with two antipsychotics. Then I would be picked up like a batter[ing] ram and taken to seclusion and I would be there for about four hours, and then I would come out and wait for it all to happen again. There would be all the sensory stuff again. I would have no opportunity to modulate. I did not have my activities. It was a cycle.

135. This cycle of adapting to the environment contributes to a well understood pattern of people with learning disabilities and autistic people being detained for longer periods of time. Length of stay was one of the key problems raised in our service user roundtable, where multiple participants noted that it was important to have access to hospital at moments of crisis, but that their stays were too long.

136. A key contributing factor to this cycle is, as we heard, a lack of understanding from and training of staff in supporting people with these conditions. We are pleased to see that new mandatory training for learning disabilities and autism was introduced this year with the Health and Care Act 2022, which should help to ensure that staff receive appropriate training.

137. However, we heard that the main driver of long-term stays is a lack of community alternatives to inpatient care. Tim Nicholls from the National Autistic Society said that “we are

in a situation where we are allowing the state to deprive people of their liberty because the state is not meeting their needs effectively in the community". Professor Mahesh Odiyoor, speaking on behalf of the Royal College of Psychiatrists, told us that the lack of community care was the primary contributing factor in long detentions, and told us that "more than 70%" of the people in his inpatient unit are delayed discharges "because they do not have a place to be discharged to, not because they need to be in hospital". This problem is discussed by the Independent Review, who noted that the MHA is being used in a way that is "not in line with its intended purpose, and is too often being used to compensate for the lack of adequate and meaningful support within the community".

The draft Bill

138. The Government said in the White Paper that they were "committed to reducing the reliance on specialist inpatient services

for people with a learning disability and autistic people and to developing community alternatives”. The draft Bill actions this commitment by strengthening safeguards already in the Mental Health Act. For example, Care (education) and treatment reviews will now be a statutory right for people with learning disabilities and autistic people, and there will be a requirement on Integrated Care Boards to maintain a register of people with these conditions who are at risk of detention. The draft Bill also removes learning disabilities and autism as conditions for which an individual can be detained for treatment under Section 3 of the MHA, which allows detention for up to six months and which can be renewed. The draft Bill still allows an individual to be detained for assessment for up to 28-days under Section 2 of the MHA. These changes will be discussed in detail in the relevant sub-sections below.

139. We have heard widespread support from charities, user-led groups, NHS groups, social care groups, clinicians and lawyers for the direction of travel in the draft Bill in respect of people with learning disabilities and autistic people, with multiple witnesses commenting that this is a “positive step forward”. Tim Nicholls from the National Autistic Society and Dan Scorer from Mencap both welcome the changes to Section 3 detention criteria, with Tim Nicholls stressing that they have been campaigning for this change for many years. NHS England has also welcomed the changes.

140. This support is qualified, sometimes heavily, by concerns that poor implementation of these reforms could lead to worse outcomes for this group. We heard significant concerns that the “community alternatives” promised by the Government are not available, and that plans to develop them are unrealistic. This may mean that people with learning disabilities and autistic people who no longer qualify for detention under

Section 3 do not receive the care they need or are still deprived of their liberty under different legal powers.

141. As explored in paragraph 20, we heard arguments that the draft Bill does not go far enough to address human rights concerns over the use of compulsory detention and treatment. Disability Rights UK, Liberation and Inclusion London said that proposals in the draft Bill still fall “well short” of compatibility with the UNCRPD as interpreted by the implementation Committee in 2017. They proposed that the Government makes “fundamental changes” to the draft Bill, in particular, by abolishing all forms of substitute decision-making, involuntary detention in psychiatric hospitals and involuntary treatment and focus instead on supporting independent living by strengthening the Care Act. The National Survivors User Network said that this is “not necessarily a consensus position” among user-led mental health groups, but commented that “the independent review

did not engage with the spirit of the CRPD” in pushing for a more rights based approach. Sir Simon Wessely noted in his foreword to the Independent Review that they did not agree with the abolition of mental health legislation that the Committee proposed. In oral evidence, Sir Simon noted that there was no consensus on this matter even among various UN Committees, and that the Review sought to take “the best bits that are implementable” from the Convention and “pushed those strongly”. The Equality and Human Rights Commission said that even though the UNCRPD had not been implemented in full, they consider that the draft Bill’s changes would help in striking the balance between different rights, should reduce involuntary detentions, and therefore welcomed them.

Community services

142. We were told that the current levels of community provision are worryingly low. Dr

Quinton Deeley, Consultant Neuropsychiatrist at the National Autism Unit, noted that at present, there is “considerable variation across the UK” in the models of care for autistic people and people with a learning disability. We also heard that funding is not the only issue. Dr Deeley told us that in some cases, services are “not merely under resourced” but that there is also “a lack of aspiration, confidence and proactivity in ensuring good outcomes for people with learning disability and autism”. Saffron Cordery, Interim CEO of NHS Providers, also told us that commissioning of learning disability and autism services can be “fragmented and disjointed” as those managing the commissioning process did not always have the relevant skills and expertise. Sir Simon Wessely was more forthright, calling community service provision “woeful” and “horrific”. Alexis Quinn shared her own experience of trying to access services:

With community provision, currently there just are not the support structures

there for people who experience even moderate distress. You have to wait years for counselling and often when you get any sort of psychological support it is not tailored for autistic people; then you get offered six sessions. That is the first problem. Often autistic people need support very quickly and the system is not responsive.

143. The Government told the Committee that additional demand for mental health support in the community “will be addressed through wider investment in mental health community services committed to in the NHS Long Term Plan”. This plan, published in January 2019, committed to reduce the number of people with a learning disability and autistic people who are inpatients in mental health hospitals by 50% by 2023/24 compared to March 2015. The Minister said that the Government is making “good progress” against this target. This would be achieved through investment

in specialist community provision including intensive, crisis and forensic community support. The Government elaborated on their short-term funding plans for 2022–2023, noting that “over £90 million” will be invested in community services and support for discharges. Additionally, the 2022 ‘Building the Right Support action plan’ set out the national plan for developing community alternatives to hospitals.

144. The draft Bill’s Impact Assessment excludes costs relating to the proposed expansion of community services over the extended time period of the Bill’s implementation, noting that “these costs are challenging to quantify” and that they “do not currently know whether the new duties in the MHA will cost more than the resource provided through the NHS Long Term Plan”. Jemima Burnage from the CQC told us that they support the aims of the Bill but “we do not feel that the impact assessment and the range of resourcing are sufficient to meet the

ambitions of the Bill”. Peter Devlin from ADASS echoed this assessment, and said that ADASS do not believe the expansion of community services has been factored in, but only “implied”. The Government has told us that the Impact Assessment will be “revised and updated” in anticipation of the Bill’s formal introduction to Parliament, but does not specify whether this updated version will include more detailed costs for community care.

145. It is clear that a sustained programme of investment is needed to meet the demands of the proposed expansion to community services. It is still not clear to us whether the Government is able to deliver on these commitments in the long term. As we heard from Dr Lucy Series, successive policy interventions such as the ‘Transforming Care plan’ (2012) and the ‘Building the Right Support’ plan (2015), have failed to reduce the numbers of detentions for this group. Dr Margaret Flynn, Chair of the Mental Capacity Forum, does not believe that the Government’s

proposals will “address the existing impasse” that has resulted from the backdrop of “grossly eroded and underfunded community support”.

146. We heard that despite challenges in community care provision, these changes in legislation are still necessary. Tim Nicholls from the National Autistic Society said failures in the social care system had for too long been used as a reason not to move forward with this change in definition. However, he said, “we are in a situation where we are allowing the state to deprive people of their liberty because the state is not meeting their needs effectively in the community”. He later noted that changes like these can be a “catalyst for change”, and would help move on from the present situation in which inpatient facilities act as a “backstop for system failure”: “If you remove the backstop, you can change the way that the system is currently operating towards relying on it”.

147. We heard that there need to be much stronger duties and much more monitoring and accountability to make sure these services are put in place. A review by RedQuadrant, commissioned by the Department of Health and Social Care, of the Building the Right Support Plan found that there have been “limited” monitoring and evaluation for investment on preventative and crisis support. Alexis Quinn recommended that there should be a duty to record and monitor where people with learning disabilities and autistic people go when they are not detained under the MHA, and especially the numbers detained under the Mental Capacity Act or the criminal justice system. Ms Quinn also recommended that the changes to the detention criteria in Section 3 do not take place until the community services are “ready”.

Long term detention

Section 3

148. Under the current Mental Health Act 1983, learning disabilities and autism are encompassed within the definition of 'mental disorder' in Part I Section 1. Individuals with a condition that constitutes a 'mental disorder' can be detained in mental health inpatient settings, both for assessment under Section 2 of the MHA, and for treatment under Section 3. As of October 2022, 52% of people with learning disabilities and autistic people in inpatient care are detained under Part II of the MHA. Under the draft Bill, learning disabilities and autism would continue to be classified as 'mental disorders', but would be excluded from a new category of 'psychiatric disorders'. Under the amended Act, only those with 'psychiatric disorders' could be detained for under Section 3 and certain other provisions. This would mean that people with learning disabilities and autistic

people could not be detained for compulsory treatment under Section 3 unless they have a concurrent 'psychiatric disorder'.

149. Individuals could, however, still be detained under Section 2 for assessment, and under Section 3 if they have co-occurring 'psychiatric disorder' which is not a learning disability or autism. These changes do not extend to Part III of the MHA, the 'forensic sections', which applies to individuals who have been involved with criminal proceedings. The Government's view is that for this cohort, "the only alternative to detention in hospital is detention in prison". As of October 2022, 39% of people with learning disabilities and autistic people in inpatient settings are detained under Part III of the MHA.

150. As discussed above, most people we heard from support the change in principle and as an acknowledgement that learning disabilities and autism are not treatable mental disorders.

We also understand that it will be important in rebuilding trust with this community, who remain at ongoing risk of detention. Alexis Quinn told us that “I live in fear, to be quite honest, that I will have a meltdown in the street and the whole process could start again”.

151. Nonetheless, we have serious concerns that the deficit in community care provision has the potential to derail these reforms and lead to worse outcomes for this group. The Independent Review did not recommend that the Government take such a step, concluding that “the risk of completely removing learning disabilities and autism from the Act is too high”. Participants in the service user roundtable told us that currently some service users were encouraged towards detention so that they could access support which was unavailable elsewhere. We heard from multiple stakeholders, including clinicians, that with Section 3 no longer available, people with learning disabilities would instead be pushed towards other forms of long-term

detention in order to access care. These routes could have much more serious consequences. We have also heard that people with learning disability and autistic people who no longer qualify for detention under Section 3 will not be eligible for Section 117 aftercare, as discussed below.

Alternative routes to detention

152. Dr Lucy Series told us that the Bill's impact assessment is "based on a naïve assumption that removing learning disabilities and autism from Section 3 of the MHA will reduce use of hospital beds" and does not consider that other means will be used to detain instead. Dr Chloe Beale echoed this, telling the Committee that "you will not end up with people with LD and autism not being held in psychiatric hospitals". Sir Simon told us that "the facts on the ground" are that people will still be able to "find ways around" the restrictions in detention criteria "unless and until there are

better alternatives”. The three alternative routes identified in our evidence were an alternative mental health diagnosis, the Deprivation of Liberty Safeguards (DoLS) of the Mental Capacity Act, and Part III of the Mental Health Act.

Alternative mental health diagnosis

153. People with learning disabilities and autistic people can still be detained for assessment for 28 days under Section 2 of the draft Bill. The Government has stated that the assessment process should seek to identify the driver of the individual’s behaviour. If it is a mental health condition, the individual could be eligible for continued detention, but if not, detention would no longer be justified and should cease.

154. People with learning disabilities or autistic people are more likely to have a co-occurring mental health condition than the general population, and many may benefit

from treatment of that condition. However, we heard that disaggregating the symptoms of a 'psychiatric disorder' from presentations of learning disabilities or autism is particularly complicated, especially if the hospital lacks specialist skills and training in learning disabilities and autism. This includes having the communication skills and the skills to make the necessary reasonable adjustments to well established therapies to make them available to people with learning disabilities and autistic people. Additionally, we heard from Disability Rights UK, Inclusion London, and Liberation that the "inaccessible and distressing conditions" that people with learning disabilities or autistic people experience in inpatient settings "often lead to expressions of trauma which are wrongly interpreted as their having a mental health condition". This may lead to a mental health diagnosis where there is none, especially in environments where there is little understanding of learning disabilities and autism.

155. NHS Providers, NHS Confederation Mental Health Network, and multiple expert and specialist clinicians have highlighted the difficulties of reaching an accurate diagnosis for a person with learning disabilities or an autistic person within 28 days. This is not long enough, we heard, to accurately assess the complex inter-relationship of biological, psychological and social factors in a patient's condition, as well as the effect of inpatient environment. We also heard that assessing someone with complex needs requires a "very multidisciplinary approach" that is difficult to coordinate in that time frame, as it involves not only the psychiatrist, but psychologists, speech and language therapists, occupational therapists and nurses. Discharge planning is also particularly challenging as it requires coordination with the relevant bodies, and would need to begin soon after admission when care needs are not yet established.

156. We heard that pressure to rush this diagnosis process could lead to people with learning disabilities or autistic people being given an “alternative” mental health diagnosis that might not be the primary cause of their distress “where clinically necessary” in order to justify continued detention, this time under Section 3. Receiving an alternative diagnosis can, we heard from Dr Deeley, be “extremely disadvantageous to the patient” because it might redirect the care pathway that they are assigned to and mean that they do not get appropriate care for their underlying learning disability or autism.

157. Additionally, mental health diagnoses that do not relate to the underlying cause of a person’s learning disability or autism can lead to prolonged detention. During the service user roundtable, we heard from one former service user that, even on a specialist autism unit, her needs were ignored, and she was treated only for a co-occurring personality disorder. It was

this diagnosis, we heard, that kept her in hospital for so long. Alexis Quinn told us that she was given six diagnoses while in hospital, and said that “it took pretty much the whole three and a half years to get rid of those, then I ended up with autism at the end”. This is because, she said, “there is confusion about symptoms”. She also notes training for psychiatrists could offer a potential solution.

158. However, given that people with learning disabilities and autistic people can find inpatient settings distressing, 28-days is still a long time. NDTi acknowledged that the question of the 28-day period for assessment was difficult to answer, as “for some people it will be too long and others not long enough”. The Government also told us that they had had difficulty in striking the right balance:

We have been trying to balance exactly that view—that 28 days may not be long enough to form an assessment,

particularly if you do not have skills or capability in diagnosing autism, for example—versus a counterargument that 28 days is a very long time if you have sensory needs and are put into an environment that may lead to a deterioration of the condition. That is what we are trying to weigh up and why we came out with preserving Section 2 as it is, but it is a very valid argument that longer may be helpful in forming a fuller opinion.

Mental Capacity Act

159. Most stakeholders who considered this topic were concerned that more people with learning disabilities or autistic people, who would otherwise have been detained under Section 3 of the MHA, might instead be detained after 28 days under the Mental Capacity Act 2005 (MCA) as described in the next two paragraphs. Dr Lucy Series referred to the MCA as an

“overflow container” for the Mental Health Act, as individuals who do not come under the Mental Health Act can come within scope of the MCA. The National Autistic Society said that leaving this option open will “undermine” the Government’s policy aims to reduce the number of people with learning disabilities and autistic people detained in inpatient settings.

160. The MCA was amended through the Mental Health Act 2007 to introduce the Deprivation of Liberty Safeguards (DoLS). The DoLS provide a framework for approving the deprivation of liberty for people who lack the mental capacity to consent to necessary treatment in a hospital or care home. The DoLS were created instead of extending the MHA because many charities and organisations view the MCA as less stigmatising and more “empowering”. In March 2017, the Law Commission published a report recommending an overhaul of the DoLS process. It recommended that DoLS are repealed and

replaced by a new scheme called the Liberty Protection Safeguards, which would streamline the process for approving a deprivation of liberty. The Government largely accepted their recommendations, and the Mental Capacity (Amendment) Bill was passed in 2019, which replaces the DoLS with the new Liberty Protection Safeguards (LPS). The new LPS provisions are not yet in force.

161. Still, many witnesses were concerned that the LPS do not provide the same protections against inappropriate detention as the MHA. We heard evidence that the Mental Capacity Act with the DoLS/LPS is not designed to deprive people of their liberty in mental health settings. For example, under the MCA it is highly unlikely that a court or Tribunal will review detention, and the Nearest Relative (Nominated Person under the draft Bill) does not have powers to object to admission and seek discharge. The Mental Capacity Act Code of Practice contains fewer provisions regarding

seclusion and restraint than the Mental Health Act Code of Practice, and patients under the MCA do not have the right to complain to the CQC about their treatment. Patients under the MCA will not have a right to a Care (education) and treatment review, and do not have any entitlement to aftercare.

162. These concerns were also raised in the 2021 consultation ‘Reforming the Mental Health Act’. The Government then acknowledged the risks of these unintended consequences and committed to “consider implications for the LPS in any reform and the design of which will be consulted on”. However, the draft Bill and Impact Assessment do not address this issue, and the Government has not committed to reform of the MHA/MCA interface. We asked the Government what they intended to do to reduce the risk of these unintended consequences, and they noted that they had consulted on the proposed changes to Mental Capacity Act Code of Practice and received feedback on Chapter

22, which explains the relationship between the Mental Capacity Act and the Mental Health Act 1983. They told us: “we will consider making further changes to this chapter in light of the proposed changes to the Mental Health Act”.

163. Dr Lucy Series spoke about restricting the use of the Mental Capacity Act in psychiatric settings as a potential approach to avoid a situation where a person with learning disabilities or an autistic person is detained inappropriately under the MCA. The Law Commission in 2017 in their report into Mental Capacity and Deprivation of Liberty concluded that “the Liberty Protection Safeguards should not apply to arrangements carried out in hospital for the purpose of assessing, or providing medical treatment for, mental disorder within the meaning it is given by the Mental Health Act”. The changes made to the Mental Capacity Act reflected that conclusion.

Part III

164. A potentially even more serious concern raised by witnesses to our inquiry is that people with learning disabilities and autistic people will instead find challenging behaviour referred to the police and be detained under Part III of the MHA, or the 'forensic' sections (i.e. individuals accused of, or serving a sentence for committing a crime). The draft Bill makes no substantial changes for people with learning disabilities or autistic people detained for assessment or treatment under Part III of the MHA. In the explanatory memorandum the Government explains this decision:

Extensive consultation with experts following the publication of the White Paper has shown that detention in hospital may be more appropriate, in the majority of cases, than detention in prison to ensure that this cohort are able to access the specialist support

they may need. The Ministry of Justice is satisfied that the current detention criteria of people with a learning disability and/or autistic people detained under Part III of the MHA enables professionals to make the right decisions for this cohort, including where this requires diversion from criminal justice settings into a hospital setting.

165. We have discussed our concerns with the difference in criteria between Part II and Part III of the MHA in Chapter 5 of this report. In the case of learning disabilities and autism in particular, this decision appears arbitrary and potentially very damaging. This perspective is not new. It was first heard in the Government's consultation on Reforming the Mental Health Act, which saw a "significant number of respondents" arguing that the proposed changes should apply equally to civil and forensic patients. Not to do so, these respondents said, would be "discriminatory" and could create a

“two-tier” system. Respondents were particularly concerned that the reforms may lead to the criminalisation of learning disability or autistic behaviours to facilitate hospital detention.

166. This concern was echoed by almost every witness we heard from on this topic, including the Royal College of Psychiatrists, the Centre for Mental Health, and the Care Quality Commission. Dr Shubulade Smith MBE, from the South London and Maudsley NHS Foundation Trust, told us that every psychiatrist she has spoken to has said that they are “really concerned” that people with learning disabilities or autistic people will be admitted instead under Part III of the MHA if Part II, Section 3, is no longer available. The Care Quality Commission told us that they “understand and sympathise” with the view that this may be in the interests of patients currently, or in the future, who are detained under forensic provisions. However, they note that the differences in criteria could “create pressure to prosecute people

with a learning disability or autistic people to access hospital placements under the MHA". Additionally, Dr Deeley said that patients with challenging behaviour are likely to present later and with "greater acuity of disturbed behaviour". This, he outlined, is more likely to divert them to the criminal justice system rather than the mental health system in the first place.

167. People with learning disabilities and autistic people in inpatient settings are already at risk of criminalisation. As detailed in paragraph 134, we heard that an inappropriate inpatient environment can lead to an autistic person displaying distressed behaviours in response to a sensory overload. A 2020 thematic review into Independent Care and Treatment Reviews for patients in long-term segregation found that restrictive practices such as restraint, seclusion, tranquilisation and long-term segregation, which are used to manage such situations of distress, can also be an aggravating factor for more aggressive and destructive behaviour.

The thematic review also found that many of the patients reviewed, who were in long term segregation, had acquired a criminal record while in hospital. As an indicator of this trend, the number of people in long-term segregation is increasing. When the thematic review began in 2019, there were 77 people detained in long-term segregation, many of whom were on a forensic section, but by 2021 its Chair said this number had risen to 100.

168. It was especially concerning to hear that this change may exacerbate an existing push towards criminalisation for those in inpatient settings. Alexis Quinn told us that is there was a “pattern” when ‘meltdowns’ occurred at the inpatient hospitals she attended, that the staff would involve the police. She felt that this motivated by a desire to “accrue a forensic record so that the hospital staff could justify a forensic pathway” to remove patients from acute units to a more secure setting, and likely to a different funding stream. Jennifer Kilcoyne from

the Centre for Perfect Care and Dan Scorer from Mencap both said that this is a trend, and that they have therefore seen an “escalation” of patients being pushed towards the criminal justice system over recent years.

169. Detention under Part III was Alexis Quinn’s main concern with the new changes. She stated that for someone with low support needs such as herself, but who was “destroying property” during a meltdown, she would be likely to be detained under Part III. She told us that “It is more life-limiting for me to have a criminal record, as a law-abiding citizen otherwise [...] I really would rather be in a hospital than in prison”.

170. Dr Arun Chopra mentioned that a comparable example of removing learning disabilities and autism from mental legislation could be found in New Zealand. New Zealand is the only common law jurisdiction that has removed intellectual disability from its mental

health legislation and did so in 1992. Dr Chopra said that this resulted in people with learning disability often being diverted into the criminal justice rather than the health pathway, and noted that further legislation had to be introduced in 2003 which replicated the rights and protections afforded by the mental health legislation. A 2022 article in The Lancet said that this further legislation resulted in “net-widening”, with “more rather than fewer people with intellectual disabilities becoming subject to compulsory care in detention”. The Government told us that, in their view, there were “limited parallels” that could be drawn.

171. As the Government has stated, the criminal justice system is not necessarily “appropriate” for people with learning disabilities and autistic people. Dr Ailbhe O’Loughlin from the University of York went further by stating that there were systemic failings in the criminal justice system’s treatment of autistic patients. A 2021 Criminal Justice Joint Inspection report

found “serious gaps, failings, and missed opportunities at every stage in the system”. The report also raised concerns regarding insufficient screening for neurodivergence and the extremely limited provision of rehabilitative support for neurodivergent people in prisons and the probation service. Dr O’Loughlin said that moving some people with learning disabilities and autism to hospital will not address these “systemic problems”.

172. For some of our witnesses, problems in the criminal justice system’s treatment of people with learning disabilities and autistic people should not be reason enough to weaken the Government’s stance on the unacceptability of inpatient environments for these individuals. The National Autistic Society said that there will still be circumstances where hospital is not a better suited environment for an autistic person, for instance, if they do not have a co-occurring mental health condition. Gail Petty from NDTi also challenged the “easy assumption”, that

hospital is a better place, noting that we also need to ensure that our criminal justice system can respond appropriately to people with a learning disability and autistic people. Dr Smith made a similar comment and told us that as a result of recent reforms, there are really good mental health services in some prisons, even including “therapeutic communities”, where certain people do better than they would in hospitals.

173. The Government has told us that they plan to introduce neurodiversity support managers in prisons, work towards an autism accreditation, and are improving staff training. The Ministry of Justice told us that they had established cross government and agency working groups “in recognition of the need for a cross system effort to improve provision for neurodivergent people” and pointed us towards their 2022 Action Plan for improving support for neurodiversity in the prison system.

174. The Government has not been forthcoming with the details of any plans to prevent this route to detention. When we first wrote to the Government asking them to outline their proposals for mitigating the risk of increased use of the MCA and Part III for people with learning disabilities or autistic people, they said that “increased community services” are “likely to benefit” those who would otherwise have been admitted under the criminal justice system. We asked the question again to the Minister, Rt Hon Damian Hinds MP, but were not told of any changes or provisions that had been made in the draft Bill or elsewhere. When we asked the question again in a letter to the Government, they told us that “the draft Bill includes sufficient provisions to mitigate this risk”, through provisions for Care (education) and treatment reviews and risk registers, discussed below.

175. Additionally, the Government does not seem to have researched the extent of any potential consequences, or what kind of support

system people might need to mitigate these consequences. In oral evidence, David Nuttall from the Department for Health and Social Care said that they do not know how many people may be directed down this route as it is “very difficult” to form a judgement without a counterfactual or an understanding of what support system might be in place in the future.

176. **We welcome the direction of travel evidenced by this legislation. Too many people with learning disabilities or autistic people have been detained in unsuitable facilities, and for too long. The draft Bill’s proposed changes to the detention criteria in Section 3 are likely to improve outcomes for this group in the long term. At the same time if these changes are implemented too soon, or without the appropriate community alternatives in place, they could prove counterproductive. A staged approach to these reforms is necessary to allow time for investment in community services and**

to test the hypothesis that increasing these services will allow the care system to deal with this group of individuals effectively in the community, including in crisis situations.

177. Additionally, evidence we heard suggested that the proposed changes may actually increase the risk of people with learning disabilities or autistic people being detained under the Mental Capacity Act or through the criminal justice system instead. In both cases this could mean longer periods of detention, with fewer legal safeguards. We were also told that there is a risk that people with learning disabilities or autistic people with complex needs will be given an alternative mental health diagnosis to justify longer-term detention, which may direct them away from the care that they need. Steps must be taken to mitigate these risks in addition to the development of community services.

178. ***We recommend that the Government conducts a review of the Building the Right Support Action plan in light of the proposals in the draft Bill. It should identify which milestones in this plan must be met to ensure that people with learning disabilities and autistic people who would have been eligible for detention under Section 3 can be supported to live in the community. This review process should include all relevant parties, including service providers and service users. The milestones outlined in this review must then be met before commencement of those parts of the Bill that remove learning disabilities and autism as a condition for which people can be detained under Section 3.***

179. ***The Government must monitor outcomes for people with learning disabilities and autistic people who are no longer eligible for detention under Section 3. This monitoring should specifically***

focus on people detained under the Mental Capacity Act or in the criminal justice system, including people detained in long term segregation. The Government should commit to act if detention by these routes rises.

180. We recommend there should be provision by which detention can be continued after the 28-days allowed under Section 2 of the Mental Health Act for people with learning disabilities or autistic people in tightly defined exceptional circumstances. This should only be available if pre-authorised by a specialist Tribunal comprising individuals with an understanding of learning disabilities or autism. The time-period should be determined in the Tribunal and subject to regular review by the same Tribunal. The conditions which constitute “exceptional circumstances” should be defined in the Code of Practice; we envisage they might

include particularly complex presentations where further assessment beyond 28 days is needed.

181. The Government should urgently review the operation of the Mental Capacity Act in this context with a view to amending the Deprivation of Liberty Safeguards (soon to be Liberty Protection Safeguards) so they cannot be used as an alternative route to the Mental Health Act to deprive people with learning disabilities or autistic people of their liberty in inpatient mental health units for lengthy periods of time and thereby undermine the intention of this Bill. We reflect that this would be a specific disorder exclusion from the Liberty Protection Safeguards, which have not yet been put into practice. We also recommend that the Government re-examine the inclusion of other specific disorders under the LPS in this context in future, for example, dementia.

182. ***If the Government decides to accept our recommendation to make the changes to the detention criteria for Part II and III the same, it will be imperative that it follows through with existing plans to provide enhanced diagnosis, care and treatment for people with learning disabilities and autistic people in prisons. The reviewing requirement outlined above should explicitly include milestones in this regard. If the Government continues with the provisions as they are in the draft Bill, with learning disabilities or autism removed as grounds for detention under Part II but not Part III of the Mental Health Act, it will be imperative that the Government develops safeguards to prevent further inappropriate use of Part III for this group.***

Safeguards

Care (education) and treatment reviews

183. The General Medical Council stated that specific measures such as a risk register and statutory Care (education) and treatment reviews are likely to prevent situations arising where people with learning disabilities and autistic people need to be detained for treatment.

184. In 2015, Care (education) and treatment reviews (C(E)TRs) were introduced in NHS England policy for people with learning disabilities or autistic people in hospital or at risk of admission. The impetus for this was the Winterbourne View scandal, which followed a documentary by BBC Panorama that revealed a pattern of serious abuse at the Winterbourne View private hospital for people with learning disabilities and autistic people. These Reviews were intended to “ensure that people are only admitted to hospital when absolutely necessary and for the minimum amount of time possible”.

C(E)TRs meetings are chaired by the local health and social care commissioner and include the service user, their family, their multi-disciplinary team, two independent experts (one of whom should be a family carer or a person with a learning disability), and a clinical expert. The Independent Review found that C(E)TRs “can be an effective way to reduce hospital admissions and for professionals to take a holistic approach to their care in the community”.

185. In 2019 the Department of Health and Social Care announced that people with a learning disability and autistic people in long-term segregation would have their care independently reviewed, and Baroness Hollins was appointed to oversee this process and chair the Oversight panel. In 2020, the Oversight Panel reported their interim findings and conclusions. The Panel found recurring patterns or issues regarding commissioning, planning for discharge, service specification and transition planning”. They also noted a lack

of accountability from commissioners, who “did not think the person should move into the community and were influenced by the cost”. The 2018 Independent Review recommended that “Health and social care commissioners should have a duty to collaborate to ensure provision of community based support and treatment for people with a learning disability, autism, or both to avoid admission into hospital and support a timely discharge back into the community”.

186. The Government has taken forward this recommendation, noting in the explanatory notes that while Care (education) and treatment reviews are part of current NHS England and NHS Improvement policy, “it has been found that their recommendations are not always being acted upon and there is often no process of follow-up”. New Section 125A makes Care (education) and treatment reviews statutory by placing a duty on the responsible commissioner to make arrangements for Care (education)

and treatment review, and for a report to be published following the review. Subsection 4(a) also sets out that the initial care, education and treatment review meeting must take place within 14 days of their detention under the MHA, or when they are given a diagnosis of autism or a learning disability, and that further care, education and treatment review meetings must take place at least once every 12 months from the date of the first review. New Section 125C also requires that the patient's responsible clinician, the responsible commissioner and the appropriate integrated care board must 'have regard to' the recommendations set out in the report produced following the review. Complementing this recommendation is the provision to introduce statutory Care and Treatment Plans on a statutory basis for certain patients, discussed in Chapter 8 of this report.

187. This move has been broadly supported, including by NHS England, VoiceAbility, Mencap and the Challenging Behaviour Foundation.

Professor Mahesh Odiyoor from the Royal College of Psychiatrists, and Dr Quinton Deeley from the National Autism Unit, questioned whether mandatory C(E)TRs would have the desired effect. Dr Deeley stated that the C(E)TR process can make an effective contribution in certain cases by focusing the minds on discharge and is useful when there is insufficient commitment to the commissioning process from responsible parties, but is not necessary where the systems are working well. The provision in the draft Bill, he says, is “a response to an unacceptable status quo that is due to the failure, where it exists, to properly apply the existing processes”. For them, the true problem was the lack of availability of community services following discharge.

188. However, others we heard from stated that it is necessary to have a stronger duty on the C(E)TR process precisely because the system is not currently working well. Those of this opinion, including the National

Autistic Society and the National Development Team for Inclusion (NDTi) and Mencap and the Challenging Behaviour foundation, have concerns that the draft Bill still does too little to make sure that actions from the C(E)TR are enforced. They say that the requirement for patient's responsible clinician, the responsible commissioner and appropriate Integrated Care Board (ICB) to 'have regard to' recommendations resulting from C(E)TRs, is not strong enough to ensure that recommendations are followed. Dan Scorer from Mencap told us in oral evidence that they want "much stronger rights for people to be able to challenge failures to act on those recommendations", such as where individuals are ready for discharge, but "commissioners are not acting on those recommendations locally".

189. The National Autistic Society suggest that the draft Bill should use stronger language that "suggests a duty to promptly fulfil recommendations from C(E)TRs unless a good

reason not to can be demonstrated. This should also be reinforced and clarified in guidance”.

They also recommended that the maximum period between reviews is reduced from twelve to six months. Mencap and the Challenging Behaviour Foundation also recommended that the time between C(E)TRs should be reduced from twelve months to six months for adults, and three months for children. NDTi echo the substance of this recommendation, noting that “a year is a very long time for young people”.

190. **The duty for the responsible commissioner and the appropriate Integrated Care Board to ‘have regard to’ the recommendations set out in the report produced following a Care (education) and treatment review is not strong enough to ensure that the recommendations are effectively acted upon. This is likely to be particularly a problem with those local authorities and Integrated Care Boards who do not currently engage with the process.**

191. ***The Government should strengthen the wording of the duty for Integrated Care Boards and Local Authorities, which currently only requires that they ‘have regard to’ recommendations in the Care (education) and treatment review reports, to ensure that the outcome of each Review is actioned effectively. This could be done either by requiring that Integrated Care Boards and Local Authorities must “follow” recommendations in the reports or by placing an additional requirement that the Integrated Care Boards and Local Authority must provide a “good reason” for not following recommendations in the reports. For example, that the recommendations are not in the best interests of the individual.***

192. ***The maximum time period between Care (education) and treatment reviews is too long, especially when recognising the detrimental effects that inpatient environments can have on people with***

learning disabilities and autistic people, particularly those who are under 18. The maximum time period between reviews should be shortened from twelve to six months.

Dynamic Support Registers

193. The Independent Review recommended that the Government should introduce a duty for health and social care commissioners to “collaborate to ensure provision of community based support and treatment for people with a learning disability, autism, or both to avoid admission into hospital and support a timely discharge back into the community”. The draft Bill does not do this directly, but instead introduces a weaker requirement for Independent Care Boards (ICBs) to “establish and maintain” a register of people with learning disabilities or autistic people in their area who are at risk of hospital admission and monitor their care and treatment requirements, called

a 'risk register'. This provision is designed to help ensure that ICBs can monitor individuals at risk of detention and put in place the necessary preventative measures to help keep people out of hospitals. There is a duty on ICBs and Local Authorities to 'have regard to' these registers and the needs of the local "at risk" population when carrying out their commissioning duties, and for them to "seek to ensure" that the needs of those with autism or a learning disability can be met without detention under Part II. It also creates a duty for the Secretary of State to set out in regulations the factors which make an individual "at risk" for detention. This will ensure consistency in how ICBs make decisions as to which individuals are eligible for placement on the register. The register will only include individuals who have consented and will not include those at risk of detention under Part III.

194. Officials from the NHS and Government stressed in oral evidence that this policy is meant to be pre-emptive "enabling local

systems to be aware of people who may be at risk of admission and put in appropriate support, in a timely and proactive way, to try to avoid crises developing where people may need to be admitted or may be at risk of offending". David Nuttall, Deputy Director of Neurodiversity, Disability and Learning Disability at the Department of Health and Social Care, echoed this position, stating that this policy was designed to "balance" the removal of people with learning disabilities and autistic people from Section 3 (discussed above). Without intervening early enough, he noted, someone with support needs "could escalate towards admission or a crisis, which might put them in touch with the criminal justice system".

195. Registers to monitor people at risk of detention under the MHA have been included in NHS England's policy and guidance since 2015, both in the Care and Treatment Review policy, which the Building the Rights Support Plan builds upon, which highlights the importance

of services knowing the people who are likely to need additional support. These are called ‘Dynamic Support Registers’ or ‘Dynamic Risk Registers’. NHS England state on their website that there is a “requirement” for integrated care boards (ICBs) to “develop and maintain registers to identify people with a learning disability, autism or both who display, or are at risk of developing, behaviour that challenges or mental health conditions who were most likely to be at risk of admission”. The National Autistic Society told us that it will be “imperative” to build on existing dynamic risk registers, “which have not had the desired impact, because of inconsistent use and a failure to proactively identify people at risk. Inclusion in the draft Bill is an important strengthening of this, but the Government will also need to issue clear guidance on implementation of the registers”.

196. We heard positive, but qualified, responses concerning the Government proposal in oral and written evidence. In particular, we

heard that it will be vital for such registers to be focused on providing support, rather than simply identifying risk of admission. The National Development Team for Inclusion reflected the general response in supporting the creation of such registers, but noting that to be effective “they must go beyond those at immediate risk of admission to hospital and drive proactive responses from public bodies rather than be a passive record”. Professor Mahesh Odiyoor said that the concept was “valid”, and commented on the effectiveness of the Dynamic Support Tool the Cheshire and Wirral NHS Foundation Trust where he works had developed several years ago. However, he was clear that there must be a clear process of identifying risk. This was also supported by Mencap and the Challenging Behaviour foundation, who said that “it is important there is consistency over criteria used, and for it to be clear what action being on the registers could prompt”. The Bill’s explanatory memorandum states that the likely

factors that would indicate an individual is “at risk” of detention will be set out by the Secretary of State.

197. Professor Odiyoor also said and that inclusion on the register must be linked to targeted support: “there is no point in identifying that somebody is at risk of being admitted to hospital unless you do something about that”. The National Autistic Society echoed this point, stressing that it is “crucial” that the identification of risk is met with the offer of further support. This point was echoed by multiple submission to our inquiry. Dr Deeley also commented that establishing a joined up approach to commissioning is key, as currently “co-ordinating effective decision-making when there are so many stakeholders and decision-makers is very difficult”. This can be a significant barrier to the provision of care services.

198. In the 2017 ‘Care (education) and Treatment Review: Policy and Guidance’, NHS

England mention “significant feedback” about perceived unhelpfulness and unacceptability of the name of the register. Simone Aspis from Liberation echoed these concerns, asking “Why would anybody want to go on a register to say, ‘I might be at risk of being detained under the Mental Health Act’? Many more questions need to be asked about that”. Disability Rights UK, Inclusion London, and Liberation said the requirement appeared “somewhat double-edged”, as whilst they may result in improved provision of support, they might also be “a danger of their leading to further stereotyping of people with learning difficulties and autistic people”. The National Autistic Society wrote to us to note that “It will be important for the Government to be cognisant of this group’s reasonable mistrust of the system when setting out regulations for the registers”. This mistrust could undermine the effectiveness of the register in identifying the local “at risk” population. As currently outlined, inclusion on

the register is based on the individual's consent, and it is possible that mistrust will lead to more individuals choosing not to be included.

199. Despite the importance placed on these registers by the Government and their key place in a policy package designed to reduce unintended consequences due to the absence of Section 3 detention, the draft Bill's provisions do not go as far as the White Paper proposal of imposing a duty on (then) Clinical Commissioning Groups to provide adequate care for autistic people and people with learning disabilities. Multiple submissions also raised their concern about the absence of a clear requirement for ICBs and Local Authorities to collaborate to meet the needs of the local "at risk" population. Clause 2, new Section 125E, only imposes a need for them to "have regard to" these registers when carrying out their commissioning duties and "seek to ensure"

the needs of people with learning disabilities or autistic people can be met without detention under the MHA.

200. It was strongly recommended by multiple submissions that this duty in 125E is strengthened. For example, the CQC said 125E needs strengthening because the duty ‘seek to ensure’ is “too weak”, and risks not having the desired effect of ensuring sufficient community based services. The Equality and Human Rights Commission recommended that ICBs should be required to ensure, so far as reasonably practicable, that sufficient services are available so that the needs of people with autism or a learning disability can be met without detaining them under the Mental Health Act.

201. Additionally, the language of “establish and maintain” ‘in new Section 125D is legally weaker than the “develop and maintain” of existing NHS policy, which implies a more active duty. The Government confirmed to us in

writing that the requirement does not include a duty to actively find out which people should be registered. Instead, there will be an “expectation” that ICBs work with GPs to identify individuals for potential inclusion and “encourage and support” a system which will proactively identify people known to their services who are at risk of hospital admission; add patients in an inpatient setting to the register, if they were not on one before their admission (with the patient’s consent); and ensure systems are in place to carry out these actions effectively. The CQC told us that this language needs clarifying.

Section 117

202. Several witnesses to this inquiry, including NHS Trusts and the Approved Mental Health Leads Network, as well as clinicians and service users, have shared their concerns that removing autistic people and people with learning disabilities from Section 3 would mean that they would be unlikely to qualify to have

aftercare costs met under Section 117 of the Mental Health Act. Importantly, Section 117 places a duty on the ICBs and local social services authorities to provide after-care to patients detained in hospital for treatment under Sections 3, 37, 45A, 47 or 48 of the MHA, who then cease to be detained and leave hospital. There are no equivalent provisions in the Mental Capacity Act. Aftercare lasts until the NHS body and the local authority jointly give notice to the person that they are satisfied that they are no longer in need of such services. The English and Welsh Codes of Practice for the MHA have state that ICBs should interpret the definition of aftercare services broadly, meaning that they can encompass healthcare, social care, housing, employment services, or other needs related to the person's mental disorder.

203. Despite the all-important duty on authorities to collaborate in the provision of care arrangements, delivering aftercare through Section 117 is still complicated. Written evidence

from Justin Leslie noted that “to anyone other than a specialist mental health lawyer, the manner of achieving this legal effect is bewildering and requires entirely unnecessary mental gymnastics to determine the right result”. Additionally, Jemima Burnage from the CQC told us that while Section 117 is a duty it was “often not acted on in a timely way with organisations coming together to deliver it”. Still, without an entitlement to Section 117 aftercare, we heard from Professor Odiyoor that people with learning disabilities or autistic people could find securing community placements even more difficult and complicated. Sir Simon told us that a person would be better off in terms of community care if they were detained under Section 3 but then had access to Section 117 aftercare, than if they were not detained under Section 3 at all. The needs for aftercare vary widely, and the share of costs between health and social care vary across the country. Additionally, many entitled to Section 117 after care do not always

receive it. The costs are not part of the impact assessment, but we estimate can vary from £100,000 to £500,000 per year per person or more, depending on need.

204. The Government told us that the existing arrangements for risk registers and Care (education) and treatment reviews will provide an alternative to Section 117 aftercare. However, as discussed above, in the proposals for risk registers and C(e)TRs, there are no duties imposed on the ICBs or local authorities to provide community care in contrast to the duties imposed under Section 117.

205. One of the key solutions we have heard to the potential unintended consequences of removing learning disabilities and autism from Section 3 was to provide a corresponding right to community care. Dr Lucy Series echoed a widely held view when she told us that “what we really need are very strong, legally backed, positive economic and social rights to the right

support, and mechanisms to insert layers of accountability". She noted that the parents of children with learning disabilities or autism often have to "fight tooth and nail to get the legal rights that are written on the statute book", and that this will continue to be the case unless we "introduce positive rights to suitable community support for people". Simone Aspis from Inclusion London noted that the structure of the MHA tied care to detention:

You are starting off with the right to be detained, and then you have the right to hospital healthcare within a detention, but you do not have a corresponding right to live in the community or a right to have the support that you need in the community. As long as you have that inequality in legislative provision there will always be bias towards not providing the support.

206. The CQC suggested that Section 117 “could be extended to underpin the need for commissioning effective and responsive community services that support patients and avoid readmission to hospital”. The Approved Mental Health Professionals Leads Network recommends the entitlement to Section 117 aftercare be extended to those in Guardianship placements. Social Care Wales said that the draft Bill could place a duty on relevant bodies, such as Local Authorities or commissioning groups to provide such services, but “additional funding or service change would be required to implement such a duty in some localities”. This mirrors the commissioning duties that are proposed for ICBs and Local authorities through the new provisions around risk registers.

207. **Given the Government's intention in this draft Bill to enable more people with learning disabilities and autistic people to be cared for in the community, it is imperative that there are not only sufficient community services for this group, but a strong enough requirement on the relevant bodies to collaborate in the provision of community care. We note that this may require additional funding to ensure sufficient and equal provision across the country but expect that these requirements can be met if the Government meets its ambitious goals for investment in community services.**

208. **In particular, one consequence of this group being removed from Section 3 is that they will effectively lose access to Section 117 aftercare. This would be counter-productive to the Government's intention of providing care in the community**

if no equivalent duties on commissioning services to provide care for this group were introduced in its place.

209. *We recommend that the ‘risk register’ is renamed ‘Dynamic Support Register’ in the draft Bill to better reflect its purpose. The Government should also consult with people with learning disabilities and autistic people to see how they can build trust in this mechanism.*

210. *We recommend that the Government should strengthen the duties on Integrated Care Boards and Local Authorities to impose a firm duty to ensure the adequate supply of community services for people with learning disabilities and autistic people, using information gathered from the Dynamic Support Register.*

211. *The duty on Integrated Care Boards to “establish and maintain” a register should be strengthened to include more proactive*

language, for example, using the “develop and maintain” duty in existing NHS policy for Dynamic Registers. We also recommend that the factors to be set out by the Secretary of State to indicate that an individual is at risk of admission have sufficient clarity to avoid the misinterpretation of risky behaviour as risk of admission, and to give clarity to individuals on the register and their families.

212. Section 117 aftercare, proportionate to need, should also be extended to patients who are admitted under the “exceptional circumstances” route recommended above.

213. The Government should commission research into the likely costs and benefits of extending aftercare, proportionate to need, to patients who are detained in mental health settings under provisions other than Section 3 of the Mental Health Act, including those admitted for more than 28 days or detained under the Liberty Protection Safeguards

of the Mental Capacity Act. Informed by this research, the Government should consider extending Section 117 aftercare, or an equivalent aftercare provision, where appropriate.

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7 Children and Young People

Capacity and competence

214. There is no minimum age limit in the Mental Health Act (MHA), which means its provisions apply to children and young people as well as adults. However, as the Independent Review noted, children and young people have specific needs in health services. This is not only because of their age and potential vulnerability, but also due to differences in their ability to make their own decisions. Attempts to both protect and empower children in these settings have resulted in a complex mixture of statute law and case law alongside the MHA that, as we heard, makes assessing a child's rights to access certain safeguards in this draft Bill complex and obscure.

215. Currently, relevant laws for deciding whether a person can make decisions about their admission or care differ across two categories of under 18s, with the first category

being under 16 and the second being 16 or 17. Those aged 16 and over are generally presumed to be capable of making their own decisions, although there are some provisions that apply only to those 18 and over. Young people of 16 or 17 are subject to the Mental Capacity Act 2005. This means that their decision-making ability with regards to the MHA is assessed in terms of 'mental capacity', and they are assumed to have capacity unless evidence shows otherwise. For children under 16, decision making ability is assessed in terms of 'competence', referring to the concept of 'Gillick competence'. Children of this age are assumed not to have competence unless evidence shows otherwise.

216. The concept of Gillick competence was established following a decision by the House of Lords in the 1985 case *Gillick v West Norfolk*, that a child aged under 16 can consent to medical treatment if they are deemed by professionals to have the maturity and intelligence to understand what is involved.

The Children Act 1989 does not provide any direction on how to determine a child's capacity for understanding. Therefore, the principles of Gillick have been widely adopted by safeguarding agencies and clinicians as a 'test' to help guide professionals in assessing a child's maturity and understanding when making their own decisions. However, as we heard from Dr Susan Walker, a Consultant Child and Adolescent Psychiatrist at Great Ormond Street Hospital, the concept is "broad" and "ambiguous", and there is no single method or defined set of questions by which it can be assessed. We have heard from multiple contributors to this inquiry that there are significant inconsistencies in how it is applied in practice. Dr Camilla Parker KC (hon), Legal and Policy Consultant at Just Equality, noted that even after 40 years we do not have clear, consistent criteria for determining whether a child is competent to make a decision.

217. The Independent Review was also concerned that there is no consistent approach to establishing competence through the Gillick competence test. They recommended that there should be a single approach, set out in statute, for establishing whether children are able to make their own decisions. They said that this should be based on the current system set out in Section 3 of the Mental Capacity Act for those over 16. This would have the advantage of bringing together the same test for all children and young people and would provide a clearer basis of evidence for decisions made on their capacity. However, the Government responded in the White Paper that, “These matters are ultimately for the Code of Practice rather than the Act itself and will form a particular focus for consultation when we come to review the Code”.

218. We have heard significant concerns that the lack of a statutory test for decision-making ability for under 16s means that children and young people will not benefit fully from the

rights and safeguards in the amended MHA. Dr Camilla Parker said, “it does not make sense not to have it in the Bill” as “so much of the Bill is premised on giving people greater autonomy and greater rights to be involved in their care and making decisions”. A number of safeguards introduced in the draft Bill depend on the capacity or competence of the person to make a decision, including choice of a Nominated Person, consent to admission, consent to treatment, and advance decisions. Charlotte Rainer, from the Children and Young People’s Mental Health Coalition, said that without a statutory test the “massive inconsistencies” in the process of assessing competence will continue to exist and children and young people may miss out on the rights of choice afforded to others. Dr Parker noted that the lack of clarity leaves children at a “double disadvantage” because it is assumed a child does not have competence unless proved otherwise. She went on to say that the Government’s decision

not to accept the Independent Review's recommendation "sits uncomfortably" with their commitments to legislate to give people greater control over their treatment, and the principles of choice and autonomy. It appears, she said, that the Government was giving with one hand and taking away with another.

219. There was support for the development of a statutory test, with the Law Society commenting that it would be "both necessary and justified". Carolyn Willow from Article 39 said that the Government's decision not to do so is evidence of them "dodging the difficult question" of how to define the test in law. Several suggested that the test is best thought of as 'child capacity', rather than competence. Dr Parker suggested that such a test could reflect existing case law by starting from the assumption that the child cannot make the decision, as opposed to the current test in the MCA which starts from the assumption that the person can make the decision. Dr Parker

set out example questions that could form the basis of the test in her written evidence, as well as discussing some other additions such as principles to support the application of the test. Carolyn Willow notes that Article 39 are “optimistic that it can be done”.

220. At the same time, the Gillick Competence test is not just used in mental health services for children and young people. This was pointed out by the Independent Review, who noted that the implications of their proposed change would go beyond the MHA to decision-making by under 16s more generally. For example, the Gillick competence test is also used in physical health settings or when accessing other child support services. The Law Society also said that “further consultation may also be required” for this change to take place. However, Dr Parker noted that while a statutory test in the MHA could apply to other areas, that decision rests with the courts and those legislating in children’s law. Dr Parker also notes

that the test to be included in the MHA 1983 could be clearly stated to be “for the purpose of this Act”. Additionally, Dr Walker did note that a potential disadvantage of putting the test in law is that this could reduce flexibility in what is an evolving area of law. Dr Parker responded that, on the contrary, “using such a test has the advantage of requiring, not preventing cases, being considered on their merit given that the test is decision- and child-specific”.

221. **Children and young people have special needs in mental health services due to their age. It is imperative that these reforms do not leave children and young people behind, and that they are guaranteed the access to safeguards and treatment that they need. The provisions in the draft Bill rely heavily on consent, capacity and competence to make decisions. This is an area where the law is complex and, we heard, in need of better definition. A**

statutory test to assess child capacity is necessary to clarify this process for children, families, and clinicians.

222. *The Government should consult on the introduction of a statutory test for competency, or “child capacity”, for children under 16. This consultation should be wide ranging and consider the wider implications of this reform on other areas of law affecting children.*

Inappropriate settings

223. We have also heard significant concerns that the draft Bill misses an important opportunity to address the continuing practice of children and young people being detained in inappropriate settings, including on adult wards and in ‘out of area’ placements. Data on children and young people’s mental health admission and outcomes is notoriously lacking, making accurate assessment of the problem difficult. The NHS’s 2016 report ‘Implementing

the five year forward view for mental health' pledged that "inappropriate locations far from the family home" would be "eliminated" by 2020/21. This has not been realised. Data that Article 39 obtained through a freedom of information request showed that in each of the years 2016/17, 2017/18, and 2018/19, over 1,000 children were placed 'out of area'. A report by the Children's Commissioner's Office found that in 2020, 21% of children and young people who were inpatients were placed more than 50 miles from their home. Data from the Care Quality Commission indicates that the number of children and young people admitted to adult wards for more than 48 hours was 191 in 2020/21 and increased by 30% to 249 in 2021/22. Most of these admissions were under the MHA and were due to a lack of age-appropriate alternatives.

224. This trend is likely to continue as the number of children and young people accessing mental health services is increasing rapidly.

In 2019/20, 538,564 children were referred to mental health services, an increase of 35% on 2018/19, and nearly 60% on 2017/18. A significant driver of this increase was the COVID-19 pandemic. Research from the Nuffield Family Justice Observatory in 2022 also found that the use of a ‘last resort’ measure by the High Court, which allows it to deprive children of their liberty in unregulated settings when a place can’t be found for them elsewhere, has increased by 462% over three years. Dr Susan Walker, commenting on this statistic, said “we are really struggling to place these young children”. Driving this difficulty is the “huge problem” of the lack of specialist children’s services.

Adult wards

225. Regarding the placement of children on adult wards, Carolyn Willow made the important point that there is no other institutional setting—be it prisons, children’s

homes, residential special schools or boarding schools—where children and adults are in residential proximity. She stated that allowing this to happen in circumstances that amount to a deprivation of liberty is in breach of Article 37(c) of the United Nations Convention on the Rights of the Child, which prohibits the detention of children with adults. She explained:

Mental health wards, as you know, are really frightening places. People are shouting; people are screaming; people are out of control. If that person who is shouting and screaming, “I’m going to kill you, I’m going to do this to myself, I’m going to do that to somebody else”, is aged 40, 50 or 60 and you are 14 years old, that is terrifying.

226. As a result of work by the first Children’s Commissioner for England in their 2007 report ‘Pushed into the Shadows’, a new provision was added to the Mental Health Act 1983 (Section

131A) requiring that patients under the age of 18 are placed in hospital environments which are suitable to their age. This duty applies to the admission of all under 18s, whether or not they are detained under the MHA. However, the provision does not necessarily prevent admissions to adult wards, but imposes a duty to ensure that the “environment” is “suitable” to the patient’s age. The MHA Code of Practice outlines that Section 131A permits admissions in “exceptional circumstances, where this is considered to be the most suitable place for an under 18-year-old”. The Code of Practice also states if a child under 16 is admitted to an adult ward, this must be reported as a serious incident. Additionally, if a child is admitted into an adult ward for longer than 48 hours, the CQC must be notified. The Independent Review recommended that this time period be shortened to 24 hours, which the Government did not accept on the grounds that 48 hours was sufficient.

227. However, Dr Camilla Parker told us that the changes outlined in 'Pushed into the Shadows' are not happening, and that this provision needs to be strengthened. Dr Parker suggested in her written evidence that potential options could include amending the duties on hospital managers or requiring the Secretary of State to approve admissions, such as already happens for children under 13 being placed in a secure children's home. Carolyn Willow has also outlined potential amendments to Section 131A, drawing on existing legislation and policy.

Out of area placements

228. Carolyn Willow told us that out of area placements have a detrimental effect on the outcomes of children and young people in inpatient care:

Poorly children are sent hundreds and hundreds of miles away by an NHS that is there to help them get better. That process makes them feel utterly

powerless, lonely, abandoned and disconnected from the very people—their friends, family and communities—who are integral and critical to them building themselves back up with help, getting strong again and being well again.

229. The Mental Health Act Code of Practice states that care should be delivered as close as reasonably possible to a location that the patient would like to be close to, for example their family or a carer. However, the Independent Review found that children and young people are more likely than adults to be admitted to an out of area placement”. NHS Providers told the Health and Social Care Committee’s inquiry into children and young people’s mental health that NHS Trust leaders, despite being acutely aware of the impact that out of area placements have on the overall quality of care, are having to do this as a last resort because of a lack of inpatient mental health beds in their local area.

230. The Independent Review recommended that the local authority for the area in which the child or young person ordinarily lives should be notified if they are placed out of area or in an adult ward or if admission lasts more than 28 days. Additionally, they recommended that the period for notifying the CQC should be shortened from 48 hours to 24 hours, and that the parents and families of young people placed out of area are supported to maintain contact. In the White Paper, the Government agreed that the local authority should be notified, but disagreed with the 24 hour notice period and family support on the grounds that 48 hours was sufficient. Dr Parker suggested that the draft Bill could do more to strengthen provisions against the use of out of area placements by incorporating procedural requirements where out of area placements are considered, and clarifying complaints procedures.

231. **Increasing numbers of children and young people are finding themselves in need**

of mental health services. It is unacceptable that, despite reforms dating as far back as 2007, children and young people are still, and increasingly, being detained in settings that are not appropriate for their age. As more children and young people come into contact with mental health systems it is imperative that there are enough specialist services to ensure that they are given the care that they need.

232. ***The Government must take the opportunity of this legislation to strengthen the protections in the Mental Health Act against children and young people being placed in inappropriate settings, such as adult wards or placements out of area. For example, the draft Bill must amend duties on hospital managers to ensure that there are sufficient services for children and young people, and there must be stronger procedural requirements where inappropriate placements are considered,***

including a requirement that such a placement is demonstrably in the child's best interests. It is imperative that these reforms coincide with developments in the provision of specialist services for children and young people to address the core driver of this problem.

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8 Patient Choice

233. The Independent Review considered Patient Choice to be central to their recommendations:

If there is one theme that runs through this Review, it is to ensure that the voice of the patient is heard louder and more distinctly, and that it carries more weight, than has been the case in the past. It is our intention that even when deprived of their liberty, patients will have a greater say in decisions, including decisions about how they are treated. We also want to make it harder to have those decisions overruled.

234. When the then Health Secretary, Rt. Hon. Sajid Javid MP, laid out the draft Bill he reiterated this, stating that its aim was to give patients more control over their care and

treatment. This followed from the Government's 2017 and 2019 Manifesto commitments to reform the Mental Health Act (MHA) so that:

Patients suffering from mental health conditions [...] have greater control over their treatment and receive the dignity and respect they deserve.

Care and Treatment Plans

235. One of the measures in the draft Bill to ensure the patient's voice is heard is the introduction of statutory Care and Treatment Plans (CTPs) for detained patients. At present, CTPs are statutory in Wales but not in England. They are required to be prepared, regularly reviewed and updated by clinicians and must, if practical and appropriate to do so, be created in consultation with the patient. The plan must set out how the patient's current and future needs, arising from or related to their mental disorder, will be met. It must also include personal information, specified in regulations, about the

patient's circumstances that is for the purpose of meeting a patient's current or future needs. Moreover, the provisions in Clause 9 introduce a duty on clinicians to consider a patient's wishes and feelings when deciding whether to give treatment, which these plans should inform.

236. This measure is informed by the first principle developed by the Independent Review, choice and autonomy—ensuring service users' views and choices are respected, and by the recommendation that: "Shared decision-making between clinicians and patients should be used to develop care and treatment plans and all treatment decisions as far as is practicable".

237. This measure was widely welcomed in our evidence. As well as involving patients in their care and treatment decisions, we received evidence that they may ensure further benefits. These included: the involvement of all relevant parties, meaning the strengths, needs, expectations and wider social context

related to a person's care may be understood and reflected; that they are likely to enhance and expand collaborative working within organisations and across service boundaries; and that they will help provide evidence that care, treatment and detention is of therapeutic benefit.

238. In our roundtable consultation, service users were critical of the way that non-statutory Care and Treatment Plans are currently used. They told us that too often recommendations were rarely actioned, and that the process can become a box-ticking exercise. They said they found this very frustrating and recommended that Care and Treatment Plans should contain hard and fast obligations to carry out the recommendations. They thought service users should be directly involved in creating their Care and Treatment Plans and that they should be distributed to all those involved with the patients care.

239. The draft Bill address some of these concerns, for example the obligation that, where practical and appropriate, CTPs should be created in consultation with the patient. However, we heard it will be important in their implementation and day-to-day use that CTPs are seen to genuinely address the concerns in paragraph 238 above if they are to be trusted and be effective. The worst consequences of the failure on some occasions of the current CTP system to do so was tragically detailed in the written evidence submitted by The Parliamentary and Health Service Ombudsman. Its investigation into the deaths of two vulnerable men at the North Essex Partnership University NHS Foundation Trust identified the failure to keep CTPs accurately updated as one of several failings that contributed to their death:

Plans were not updated to reflect all the patients' needs or address all the risks present such as risk of suicide, reports of rape, substance abuse, aggression

and non-compliance with the prescribed medication. There were no mitigation plans for present risks.

Advance Choice Documents

240. Advance choice documents (ACDs) were tools recommended by the Independent Review that allow a patient to state and record a range of preferences when they are well, which they would like to be considered if they become ill. They can include a variety of issues from care and treatment preferences, and people they would like contacted, to their wishes and feelings on more personal and practical matters, such as who might make any financial decisions for them.

241. The Independent Review recommended that “statutory advance choice documents should be created that enable people to make a range of choices and statements about their inpatient care and treatment”. The White Paper recommended that it be a legal requirement

that ACDs be considered when a patient's Care and Treatment Plan was developed and that they should have "real power and influence over decisions and appeals regarding care and treatment". The draft Bill recognises advance decisions as set out in the Mental Capacity Act, for people 18 or over to refuse certain treatments in advance in anticipation of later lacking the capacity to decide. However, it does not provide for ACDs.

242. The Government is supportive of non-statutory ACDs and says the NHS has begun to work on a template to be used for them. It explained that the reason it had not included a statutory right to have ACDs considered when a Care and Treatment Plan was developed was because of a concern about creating a hierarchy of documents, and allowing flexibility in how advance decisions were made. For example, they said a patient's needs may mean they prefer to make such decisions in ways other than writing, orally for example, and that these

should have the same validity. Moreover, this was informed by the approach taken under the Mental Capacity Act 2005, which the Government wanted consistency with.

243. In her oral evidence Dr Lucy Stephenson, a clinical research associate at King's College London who works on ACDs, pointed to the difficulties involved in this approach:

To contrast with the draft Bill, there is reference to advance decisions, and needing to take note of the patient's past and present wishes, but there is no structure on where you would find those, or how you go about recording them.

This really is a recipe for a lack of clarity for service users and clinicians seeking to make and use these documents.

Advance choice documents would bring us more in line with the legislation in the Mental Capacity Act because there

is more nuance; there is more room for detail about care rather than just treatment.

244. Dr Arun Chopra, Medical Director of the Mental Welfare Commission for Scotland, pointed to the experience in Scotland where the Mental Health Act 2003 had not included the right to ACDs on a statutory basis, stating that there had only been a 6.6% take up. He suggested that we should recommend further strengthening the offer of ACDs “so that when someone has had an episode of compulsion, there must be a mandatory offer from the NHS trust or local authority to ensure they have the opportunity to make an advance decision”.

245. A number of witnesses were in favour of the statutory inclusion of ACDs in the draft Bill because of the role they could play in strengthening the patient’s voice and improving treatment and outcomes. They highlighted other advantages, including research in which

health professionals reported increased clinical efficiency and better communication, and improved decision making under crisis. Other research suggested that ACDs may reduce compulsory admissions by around 25%, leading to cost savings:

Detentions under the Mental Health Act on average cost £18k, and if ACDs reduce 10% of detentions (a conservative estimate), that would be 5,000 people a year, at a cost saving of around £90 million.

246. We also heard evidence about the role ACDs could play in increasing trust and redressing the power imbalance between black and ethnic minority patients, and mental health services. The specific value of ACDs and the process through which they might redress inequalities was highlighted by Maurice McLeod, then-CEO of Race on the Agenda:

Our thinking, along with Mind, is that, if a patient has these ACDs, they are much more likely to be thinking in advance. They are much more likely to get early intervention. They are much more likely to, I hope, get the resources, support and whatever they might need as they go along the process and therefore much less likely, I hope, to enter the mental health service through the criminal justice system or through other unpleasant means. It encourages early intervention as well, but there is something more about empowering the individual to feel like they are having more of a say, to feel like they are going to be listened to, and to know that, when their records are looked at, their views will be taken into account.

In our oral evidence session dedicated to the role the draft Bill could play in reducing

racial and ethnic inequalities in mental health there was unanimous support for the statutory inclusion of ACDs in the draft Bill.

247. In our service user roundtable, one service user told us about their positive experience with a 'patient passport' which contained information about their previous admissions to inpatient services, notes about situations that are triggering, and about medication that had or hadn't worked. Though this is not exactly the same as ACDs as described in this report, this 'patient passport' included things that could go into an ACD. Moreover, it was used in the same manner as is envisaged for ACDs, to empower the service user and have their voice heard at a time of crisis. The service user told us that this document had been useful when he was previously in crisis and had been detained in a police cell. The police were able to check with a local hospital to see whether he was known, which resulted in him being cared for appropriately. He told us that the document

now gives him confidence that, should he be detained again, he has this information to fall back on.

248. We also heard evidence that if ACDs are to provide the type of benefits outlined above, they need to be created in a meaningful and truly interactive process that involves the patient. In her evidence, Professor Rose McCabe, Co-Director at the Centre for Mental Health Research, City, University of London, emphasised the need for high quality, meaningful conversations between patients and practitioners when drawing up such documents. She told us how her research suggested this was lacking even when clinicians thought they were explicitly involving patients in such conversations; and hence the need for training that involved people with lived experience of mental illness to effectively deliver the benefits of ACDs. This would also apply to the creation of Care and Treatment Plans.

249. Dr Lucy Stephenson and others reported on a pilot of ACDs at South London and Maudsley NHS Trust, pointing to further ways that patients could be meaningfully involved in the creation of ACDs and warning of negative consequences if they were not:

A consistent message [...] is that additional support is required to help service users draft, discuss and disseminate their documents. This additional support should ideally be someone who is independent of the service users' treating team and therefore in a position to address power imbalances inherent within psychiatric care. These supporters could be trained advocates, peer supporters or clinicians [...] There is a risk if care co-ordinators will be expected to work on ACDs on top of everything else, with no extra

resources, the result will be poorly completed documents and demoralised care workers.

250. We asked the Government what support it envisaged would be available to support the creation of ACDs. In reply it said:

NHS community mental health teams and the voluntary and community sector organisations will play an important role here, as well as mental health advocates who will be particularly integral to ensuring that ethnic minority groups benefit from the new rights around advance decision making provided for by the draft Bill.

Though the Government did not specify Independent Mental Health Advocates in this answer, the Impact Assessment modelling does and states they will support people in the creation of non-statutory ACDs. We received evidence that if IMHAs were to be involved

in their creation in the community, prior to an episode leading to detention, then there would need to be an amendment to the MHA to widen the eligibility to an IMHA. Currently people are only eligible for IMHA support if they are detained in hospital or on a CTO.

251. The Government also referenced the work of South London and Maudsley NHS Foundation Trust and King's College London in creating an implementation model including the development of an ACD template. It stated that it intended to "further test this model with delivery partners, with view to developing guidance for professionals and best practice recommendations for the sector".

252. We also received evidence which concerned the practicalities of creating and recording ACDs in such a manner that they were available, up to date and accessible to the range of professionals who would need to consult them when presented with a patient in

crisis, and how to ensure professionals were aware they should be consulting it. Dr Subulade Smith, Dr Lucy Stephenson and Professor Claire Henderson recommended codifying a basic standard of checking that included asking GPs to check the patient's records. We heard evidence that a potential model for such a system arises from developments in palliative care:

We have made links with the palliative care world, which has been putting a lot of effort into helping people make advance care plans around place of death. They have made a big pan-London database called Coordinate My Care to support this effort and it is much more advanced, embedded in clinical practice, and an expected part of routine clinical care. This is something that paramedics, urgent care teams and

GPs can access, which is something that would be really important to see for mental health.

253. **We welcome the introduction of statutory Care and Treatment Plans. We have heard a lot of evidence that these can be strengthened by also including statutory advance choice documents. We heard that these can be highly effective in improving outcomes such as reducing detention and increasing the efficacy of treatment by involving the patient more fully in their overall treatment, care and life decisions prior to them becoming unwell. However, for them to have the potential to do so, research suggests patients must be meaningfully involved in the creation of the advanced choice document.**

254. ***We recommend that there should be a statutory right for patients who have been detained under the Mental Health Act***

to request an advance choice document be drawn up. These should also be offered to everyone who has previously been detained, as recommended by the Independent Review. This provision should extend to people with learning disabilities or autistic people who have been detained under the MHA, including Section 2, Section 3 prior to the commencement of the changes in the draft Bill, and the ‘exceptional circumstances’ route outlined in paragraph 180. They should be recorded in a way that is accessible digitally, linked to a patients’ GP records, and usable quickly in crisis settings, including by first responders such as the police and paramedics.

255. We heard evidence that when the patient is meaningfully involved in the creation of their ACD this helps build trust. Therefore, we recommend that to facilitate such involvement this should be done with

the support of a trained person who is independent of the service users' treatment team.

Tribunals as a means to appeal a treatment decision

256. The Independent Review noted that currently the only way to appeal treatment is “by way of Judicial Review, [...] we have reached a firm conclusion that it is simply inaccessible. It is both too difficult and too expensive”. It went on to recommend that patients should be able to appeal treatment decisions at the Mental Health Tribunal, within 14 days of the Care and Treatment Plan being drawn up or after a major change of treatment, and following a SOAD review. This supported the aim of increasing patient choice and autonomy, and their increased involvement in treatment decisions. The White Paper said the Government would seek to include this. However, it was not in the draft Bill.

257. The Government explained that it had decided not to include this measure in the draft Bill after hearing many concerns during the consultation process. These focused on the power of a single judge, rather than a multidisciplinary panel, to intervene in clinical decision making without the necessary expertise to do so, resulting in a possible risk to patient safety. We asked the Government why it had given these concerns greater weight than the views of the Independent Review, and whether it had considered a pilot to test the validity of them. In reply, it said that it was not considering a pilot because it did not think a new right to appeal was required. It stated that it had re-examined the desired impact of the proposal to strengthen patient choice and their involvement in treatment decisions, and concluded this had been achieved through other measures, such as:

[...] the 'clinical checklist', (Clause 9)
which requires responsible clinicians

to follow a number of steps to ensure that treatment decisions are patient-led; the 'compelling reason' criteria (clause 11), which limits the use of compulsory medication, where it is in conflict with a valid refusal (either in advance or at the time), to exceptional circumstances; and increased oversight by the Second Opinion Appointed Doctors' (SOAD) service.

258. Questioned on the initial concerns around the power of a single judge, Sir Mark Hedley, a retired High Court judge and a Vice Chair of the Independent Review, said he felt the concern was not warranted:

We are thinking of where a doctor proposes a treatment [...] We are saying that there may be a proper place for a tribunal judge who does not need a

doctor or an assessor or anyone sitting with them for this purpose. It can be done certainly by a judge alone.

Is that patient entitled in those circumstances to refuse that treatment?

First, they are not entitled to refuse treatment altogether. We are not entitled to tell doctors what to do. The issue is whether they can refuse this treatment.

Am I [the judge] satisfied that there is an alternative that is at least good enough?

If there is, I may pay very close attention to their desire to refuse that treatment because they have a history of the side-effects of the treatment or something like that that is peculiar to them but which is important. It is that kind of role.

259. We heard evidence in support of this measure as a way of strengthening the patient's voice. Dr Jacqui Dyer, of the Mental Health Foundation and Black Thrive, told us how black

and other ethnic minority patients, found it harder to receive non-drug-based treatments. Sophie Corlett, Director of External Relations, Mind, saw tribunals as one way to redress this:

One thing we would like to see that has not been put in is the tribunals having some powers over care and treatment. Mary has already mentioned that once detained, there are issues particularly for black men around higher dosages and being much more likely to be given medication than other sorts of treatment. At the moment there is nowhere you can take that into the tribunal. We think it would redress that power imbalance that exists even more for black people if the tribunal was able to look at those as well. That is a big missed opportunity for us.

260. The Law Society also supported the idea of a formal route, independent of medical

professionals, to challenge treatment. However, they qualified this by also questioning how effective a lone judge might be, and whether to refer a decision back to the responsible clinician for reconsideration constituted too limited a form of redress for a patient who might have been expecting the tribunal to reach a different decision, possibly recommending some other form of treatment. They warned that this might cause the patient to lose trust in the tribunal system.

261. **Although the draft Bill does not include the ability to appeal treatment decisions to a tribunal, it does propose other measures, detailed elsewhere in this report, that would increase the frequency of appeals to tribunals. We heard a lot of evidence about concerns that such an increase would have a serious impact on the workload of mental health professionals. As such we are mindful that in recommending the inclusion of this measure, we must do**

so in a manner that allows for mitigation against any further increase in workload in as far as this is possible.

262. The draft Bill does not include the Independent Review's recommendation that treatment decisions may be referred to a tribunal. We have heard that such a measure would strengthen the patient's voice. However, we recognise the concerns about the potential conflict between clinicians and tribunal judges, and about the potential increase in workload for medical professionals.

263. *We agree with the Independent Review that a slimmed down Mental Health Tribunal should be able to consider whether a patient is entitled to challenge their treatment plans, if requested, following a Second Opinion Authorised Doctor review of their care and treatment plan or a major change in treatment. We recommend that*

the Government amend the draft Bill to allow for pilots in the first instance, to ensure that the additional workload is manageable and the Tribunal and clinicians' roles are not compromised.

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9 Nominated Persons

Proposals for the Nominated Person

264. The Independent Review made several recommendations around replacing the existing “Nearest Relative” with a “Nominated Person” (NP) under their principle of Patient Choice and Autonomy. Currently, the patient’s nearest relative is given certain rights over their care including the right to require an assessment to be made with a view to admitting the patient to hospital, the right to apply for compulsory admission or guardianship, and the right to be consulted before an approved mental health professional makes an application for detention. A patient’s “Nearest Relative” is defined according to a hierarchical list in law. The Independent Review concluded “There has been wide opposition to the current concept of the “Nearest Relative” and widespread support for the proposition that the patient should be able to choose their own ‘nominated person’”.

265. The Review said that powers “to nominate the person they want to have special rights and the ability to make advance choices about treatments could be game changers”. The powers proposed for Nominated Persons include those that presently apply for the Nearest Relative. In addition, they would allow the NP the right to be consulted about statutory Care and Treatment Plans, the right to be consulted about transfers between hospitals, renewals and extensions to the patient’s detention or Community Treatment Order, and the power to object to the use of a Community Treatment Order.

266. These recommendations were broadly accepted by the Government and reflected in Clauses 21–25 of the draft Bill which introduce the new statutory role of the Nominated Person. A patient with capacity/competence will be able to select a Nominated Person (NP) to represent them who would be able to exercise all the

statutory functions that the current Nearest Relative can, along with the new rights and powers.

267. The evidence we have received has broadly welcomed the proposals, recognising that in many instances individuals may wish to nominate people from outside a defined order of family hierarchy. Respondents to the survey were also generally supportive with one respondent saying, “I cannot express how much this needs to happen!”. The British Association of Social Workers said, “We support changes to introduce the Nominated Person (NP) as this empowers an individual’s choice and better reflects the range of diverse living and family arrangements”. The Government identified these as reforms which can be implemented quickly and which are not resource intensive.

268. There were some recommendations from the Independent Review which were not fully implemented—for example, whilst the

White Paper included proposals for Interim Nominated Persons (INP) to be appointed by the Approved Mental Health Professional (AMHP) and through any advanced choice document (ACD), there is no reference to INPs in the draft Bill. The Approved Mental Health Professionals Leads Network, who are central to the making the proposal work in practice, raised several practical concerns around the proposed role and process. They said in their written evidence that “in their present form, the NP proposals are operationally unworkable and that further development is required on this part of the Bill to ensure that the aims of the MHA Review are met and that the resulting Act is both workable and meaningful”. In their oral evidence the AMHP Network expanded on these concerns, they made clear they were supportive of the change in principle but were concerned about the potentially bureaucratic process by which nominated persons are appointed and the role of the AMHP in this. They raised situations in

which this would be extremely challenging, for example instances where an AMHP might be required to simultaneously witness signatures in person in different geographical places.

269. VoiceAbility also raised a related practical challenge surrounding these reforms and expressed surprise at the draft Bill specifically referencing Independent Mental Health Advocates (IMHAs) as being one of the groups of people who can legally witness the nomination and acceptance of a NP. They argued that this compromised the ability for an advocate to independently support the patient in the event of there being a dispute about the selection of a Nominated Person and recommended that IMHA responsibility for witnessing nomination or acceptance of an NP be removed from the Bill.

270. ***The Nominated Persons provisions for adults are welcome, necessary and reflect the Principle set out in the***

Independent Review to support patient choice and autonomy. We recommend that the Government work with Approved Mental Health Professionals to revise the proposals to address the practical concerns that have been raised with us and ensure the benefits of these reforms as envisaged by the Independent Review materialise.

271. ***There will be benefits for service users and professionals if as many people as possible nominate their Nominated Persons in advance of a crisis situation. Earlier in this report we recommended a statutory right to request an advance choice document. We recommend that the choice of Nominated Person is included in such documents. We also envisage that as part of the Mental Health Commissioner's advocacy and support function, they may wish to promote the value of specifying a Nominated Person at or soon after the point of diagnosis.***

Children and Young People

272. The draft Bill's proposals to change the "Nearest Relative" role to a "Nominated Person", as outlined above, also apply to all children and young people under the age of 18. A Nominated Person must be over 16, unless the patient is under 16, in which case the NP must be over 18. This change has been welcomed by the Children and Young People's Mental Health Coalition. We also heard that children and young people welcome this change. All the young people who participated in the 2021 YoungMinds workshop on the Mental Health Act were positive about this change, noting that they want to be able to nominate a person that might not necessarily be a parent.

273. Both the Independent Review and the Government in the White Paper agreed that young people between 16 and 17 years old should have the same right to choose a Nominated Person as adults. However, the

Review noted that the situation for children under the age of 16 was more complicated and recommended that the Government consult on the question. The Government did so in the White Paper consultation, which asked whether those aged under 16 should be able to choose a NP (including someone who does not have parental responsibility for them), where they have 'Gillick competence' to make this choice. 67% of respondents agreed with this proposal. The Government decided to move forward with the proposal.

274. The NHS Confederation Mental Health Network said there are potential safeguarding issues in allowing someone under the age of 16 to choose their nominated person, even if they are Gillick competent. These concerns were also expressed by respondents to the White Paper Consultation. The Government told us that the procedure of choosing a Nominated Person, as explained above, will have safeguards in place for all patients. It is

important that in the process of simplifying the procedure, as we have recommended, that safeguards that could protect children in particular are not overlooked.

275. The most challenging issue that we heard raised was around the potential for legal conflict if a child or young person chooses a Nominated Person who does not have Parental Responsibility, as defined in the Children's Act 1989. Under the amended 1989 Act, the term "Parental Responsibility" is defined as "all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property". This can give parents the right to determine consent to treatment in many cases, albeit that determining the extent of these rights can be difficult and has been challenged in several cases. The Independent Review notes that "exceptionally, a young person with capacity may have nominated someone other than one of their parents to be their Nominated Person".

However, it also says that “it is important to recognise 16 and 17 year olds as autonomous individuals, even if they make unwise decisions”. The Review therefore recommended that parent and carer involvement is outlined further in the MHA Code of Practice. The Government has agreed with this position and will be amending the Code of Practice accordingly, but does not go into further detail about other conflicts with parental responsibility.

276. Despite the Government’s commitment, both Dr Susan Walker, Consultant Child and Adolescent Psychiatrist, Great Ormond Street Hospital, and Dr Camilla Parker, Legal and Policy Consultant at Just Equality, commented that it did not seem that the potential problems of extending this right to children and young people had been sufficiently thought through. These problems, along with potential solutions, are outlined in detail by Dr Camilla Parker in her written evidence. In summary, the key points are as follows:

- The Nominated Person may seek to discharge the child or young person from hospital, or object to a person's detention under Section 3, irrespective of the wishes of the parents. This becomes an issue if parents with Parental Responsibility do not want the child to be discharged. It might be that they cannot provide suitable accommodation, or that they consider that the child may pose a risk to siblings.
- The provisions regarding the AMHP's appointment of a NP in situations where a child lacks capacity do not fully take into account the provisions of the Children Act 1989 on Parental Responsibility. This is likely to give rise to confusion in practice and could lead to the AMHP choosing a parent where, for example, a Local Authority has Parental Responsibility. This could lead to safeguarding concerns.

- There are no provisions for children and young people to be informed of the powers of the Nominated Person. There are no provisions to ensure that parents are aware of their rights to appeal to the Court of Protection to challenge the child's Nominated Person appointment.

277. The Government told us in written evidence, before these issues were raised, that the safeguards in place in the Nominated Person appointment process were sufficient to mitigate safeguarding risks for children and young people, commenting that “the nomination is a formal process in which a health or social care professional must witness the nomination in order to confirm that both the patient and the nominee understand the role and the implications of their decisions, and that no coercion is taking place”. The AMHP Leads Network also wrote to us to say that existing mechanisms and safeguards would be in place to protect the child's best interests, and that

these go “someway” to addressing the concerns raised. The Minister told us that she would be “very happy” to look into potential issues further to ensure that “the safeguards are as robust as they can be”.

278. **It is important that people who are eligible for detention under the Mental Health Act have access to the important provision of being able to choose a Nominated Person. Whilst welcome, extending this right to children and young people is not necessarily simple. We note with concern that some potential conflicts with the Children’s Act 1989 do not appear to have been fully thought through and are surprised that this was not addressed by the relevant departments before reaching our Committee. We welcome the Government’s commitment to look again and explore the issues that we have raised.**

279. ***The Government should consult specifically on how Nominated Person provisions will apply to under 18s in regard to potential conflicts with other legislation affecting children, such as the Children Act 1989. It should come forward with new proposals on how the Nominated Person provisions will apply to under 18s at an early stage in the Bill's progress.***

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10 Advocacy

Introduction of an 'opt-out' advocacy scheme

280. Mental health advocates support people with 'mental disorders' as defined under the Mental Health Act (MHA) to understand and stand up for their rights, and express their views and wishes. There are several different types of Mental Health Advocate:

- An Independent Mental Health Advocate (IMHA) is a statutory advocate who is available to support someone who is detained under the Mental Health Act.
- Community advocacy is commonly understood to refer to all advocacy that is not a legal entitlement. It can support people in a range of day-to-day situations such as, health and social care

appointments, workplace issues, benefit claims and appointments, and housing issues.

- Peer advocates are people with lived experience of a mental health problem.
- Culturally appropriate advocacy meets the needs of peoples' religious, cultural and language requirements.

The Independent Review heard strong evidence that advocacy was valued both by patients and clinicians because it enables patients to understand and exercise their rights and supports both groups in making shared decisions.

281. The Independent Review wanted to enhance and extend advocacy provision and improve access to IMHAs, with consistent promotion and delivery across all Trusts so all who would benefit from advocacy received it. It recommended that Independent Mental Health Advocate services should take the form

of a statutory 'opt-out' scheme with all mental health inpatients having a statutory right to being offered the services of an IMHA, which they can refuse if they wish.

282. Currently, only patients compulsorily detained under the Mental Health Act have a right to an Independent Mental Health Advocate (IMHA). The Independent Review recommended that this right should be extended to include what they called "informal" (or voluntary) patients. It had heard evidence that these patients were inadequately informed of their rights and status as voluntary patients and that the threat of compulsory admission was sometimes used to make them comply with coercive instructions such as preventing them leaving hospital grounds or forcing them to take medication.

283. The draft Bill goes some way to accepting and implementing these recommendations. It extends the statutory right

to an IMHA to all mental health inpatients to assist in decisions about their care—voluntary or involuntary. This brings England into line with the position in Wales. The intention of the reforms is to improve uptake of IMHA services so that all those who would benefit from advocacy will be able to access services.

284. The draft Bill also introduces a form of ‘opt-out’ advocacy. This is achieved via a duty on local social services when commissioning IMHA services to ensure that providers arrange a visit and determine if the patient wants to use IMHA services or not, and a duty on the managers of the hospital or registered establishment to refer all patients to the IMHA provider. However, this ‘opt out’ system does not include informal patients. For this group it only includes a duty to give information on the availability of IMHA services to English qualifying informal patients.

285. At our roundtable, service users told us that the focus on advocacy was important and welcome. We also received evidence that strongly supported these measures, although some witnesses commented on the potential limitation of the opt-out scheme only applying to “formal” (or compulsory) patients. The Care Quality Commission (CQC) supported it as something they had long called for, “as opposed to the current much more limited duties on hospital managers simply to inform patients that advocacy is available”. The extent of these limitations was highlighted by a number of witnesses, including Jonathan Senker, the Chief Executive of VoiceAbility, an independent charity and one of the largest suppliers of advocacy services in the UK:

At the moment, the duties are on the healthcare provider staff to inform people about the right to advocacy. It is

a weak duty to inform. Does it mean a poster on the ward or a quick chat, “Oh, there is an advocate if you want one”?

286. We heard strong evidence from a range of witnesses recommending the extension of the opt-out scheme to informal patients, with some echoing the Independent Review’s initial concern around the threat of compulsory admission being used to coerce patients to comply, with advocacy as a means to ensure informal admission is truly voluntary.

287. We also heard evidence that, with the opt-out scheme as it is currently described in the draft Bill, most children would not automatically have the opportunity to access an advocate as around two-thirds of them are informal patients and that by their nature they were a group for whom advocacy was vital.

Resourcing for Independent Mental Health Advocates

288. The Impact Assessment for the draft Bill estimates a central scenario over the twenty-year period from 2024 to 2044, showing an overall estimated additional cost of around £571 million to fund the growth in IMHAs. The additional spend each year reaches around £31 million in 2028/29, increasing to around £33 million from 2034/35 onwards. The estimated extra number of full time equivalent IMHAs required each year increases from 244 in 2024/25 to 616 in 2034/35 and stays at or around this figure culminating in 619 additional IMHAs in 2043/44.

289. Senior representatives of the CQC, the Mental Health Network NHS Confederation, the NHS Providers and the Association of Directors of Adult Social Services (ADASS) all concurred

that the impact assessment had not fully considered the implementation of the proposals, with Peter Devlin of ADASS commenting:

The impact assessment assumes that some of the new roles, with the IMHA role, the changes in detention and the nominated person, will be relatively straightforward to implement. We think that there is much more complexity in some of those areas that would need to be worked through, and we suggest a rethink around the implementation and sequencing of some of that.

290. We heard specific evidence regarding the estimate of resources to deliver the opt-out advocacy scheme and their availability, with witnesses suggesting that further work needed to be done on this. NHS Providers informed us that many Trusts thought “the focus should be on increasing resources for advocacy services first and foremost”, but also that “it will require

investment and additional training, with particular resource implications for local authorities given current commissioning arrangements". The British Association of Social Workers (BASW) noted, however, that:

The current IMHA services are under-resourced and the proposals for IMHAs are highly resource-dependent, with further extension of advocacy provision being subject to the availability of funding. This leads to concern that funding may not materialise.

291. At our service users roundtable, we heard from one service user who works closely with advocacy services. He expressed his concern that they do not have the capacity to meet the increased demand resulting from the draft Bill's proposal to make advocacy services statutory.

292. Witnesses working in the advocacy sector, whilst acknowledging they have similar

concerns to those above, sought to assure us that if they had the resources, they thought they would be able to deliver the workforce. Moreover, we heard evidence about the role that proposals for new legislation can have in driving innovation, with the example of one organisation already piloting trainee roles for advocates as a route to becoming a fully trained advocate in anticipation of the draft Bill becoming law.

293. One way that the costs for increased advocacy services might be offset is through their potential to reduce detention rates. Lily Huggins, the Assistant Head of Operational Development at Gaddum, the organisation running one of the culturally appropriate advocacy pilots (described in more detail in the following section on culturally appropriate advocacy) funded by the Department for Health and Social Care (DHSC), told us that the availability of such advocacy had been beneficial for people at risk of detention. As they had not yet been detained, they did not qualify for a

statutory Independent Mental Health Advocate. However, the availability of culturally appropriate advocacy had been supportive in preventing detention. In the same evidence session Dr Jacqui Dyer, Director of Black Thrive, another of the culturally appropriate advocacy pilots funded by the DHSC, told us, “We have also started seeing reduction of lengths of stay as a result of having advocacy to support people when they are detained”.

294. Addressing concerns about the overall need for an increase in advocacy services, we heard evidence about how the development of peer support could potentially ease such pressures. We were told that research had shown that black people who had been admitted under the Mental Health Act and were provided with peer support were much less likely to be readmitted after 12 months. This support had allowed them to form more trusting relationships than they could with staff, forming a “protective factor against readmission”. Moreover, the

British Association of Social Workers told us, “The development of IMHA support is one of the changes with the most potential to change experiences of admission”.

295. ***We welcome the “opt-out” advocacy scheme for detained patients. Once capacity has been built up in the advocacy sector, as measured against the annual Independent Mental Health Advocate workforce modelling targets in the Impact Assessment, it should be extended to include informal (voluntary) patients as well. This would bring particular benefits to children and young people, most of whom are informal patients. The Bill should include the powers to do this, to be commenced only once capacity exists to support informal patients on top of those who have been detained.***

Specialist Advocacy Services

296. Although the Independent Review did not include it as a recommendation, it did

suggest that statutory advocates and providers should be aware of overlaps with other forms of advocacy, particularly acknowledging the importance of this for people with learning disabilities or autistic people, and for children and young people, who were likely to have multiple advocacy entitlements.

297. Several witnesses echoed this by telling us that specialist advocacy training would be required for people with learning difficulties and autistic people, and for children and young people, if it was to be truly effective, and that general advocacy services should be flexible enough to make reasonable adjustments when necessary for these groups. The Independent Review noted the type of adjustments and specialist training that might be necessary for people with learning disabilities and autistic people. This includes how to advocate for such people when they don't communicate with

speech, or only use very limited speech, and ensure they can make fully informed decisions about their care.

298. VoiceAbility told us that many autistic people and people with learning disabilities had had particularly adverse experiences in hospital including very long periods of detention. They recommended that the Government should commission a national specialist service for them which would be accountable for quality and availability of advocacy. They thought such a service should have capped caseloads, more highly trained specialist staff with the ability to work more closely with the person and their family on a long-term basis. It should be able to work across geographical and legal boundaries and include providing services to private and independent hospitals, which are independent from the in-house advocacy services often commissioned by such organisations.

299. Specialist advocacy training is also required to meet the needs of children and young people. Dr Susan Walker, Consultant Child and Adolescent Psychiatrist at Great Ormond Street Hospital, told us that to be effective:

It is really key to ensure that the advocates are properly trained in child and adolescent mental health care and mental health law, because it is different from adults. We hear from young people that sometimes the advocates they see are brilliant and lovely but do not have the necessary experience or knowledge because they have not had access to that training.

300. Dr Camilla Parker, a legal and policy consultant at Just Equality, told us about the significant legal differences between children and young people's law and that for adults, especially relating to issues of consent and the

involvement of adults in mental health settings.

Moreover, Carolyn Willow, the Director of Article 39, a charity advocating for children's rights in institutional settings, told us about the role an advocate can play in facilitating communication and understanding between clinicians and children who are patients.

She stated that children found hospital a "bewildering, frightening environment, often hundreds of miles from home [...] it is an abnormal experience for children to be in". She said that the right to an advocate was vital in this environment if the child's wishes, feelings and views are to be communicated and understood, adding:

The advocate helps the doctor, too, not just the child. The advocate helps the doctor know that child, what that child is thinking and feeling, what that child understands around why they are in hospital and why they are suffering as they are, and what makes them more or

less frightened, distressed and agitated.
This is all part of them recovering from
their mental ill-health, so it is vital.

301. **We heard evidence that for advocacy to be truly effective, people with learning disabilities and autistic people would require specialist services, as would children and young people. We also heard that such services would be delivered most effectively if they were commissioned on a centralised basis for England.**

302. ***There are shortages of advocates with the specialist knowledge of learning disabilities and autism, relevant language skills or cultural knowledge to support patients with specific needs. The Government should examine the case for a Central Advocacy Service, to meet the needs of specific groups who may otherwise go unsupported in some areas.***

Culturally Appropriate Advocacy

303. Culturally appropriate advocacy is when “advocates can meet the needs of people’s particular religious, cultural or language requirements to help them effectively advocate for the care and treatment they need”.

304. The aforementioned Government-funded pilots of culturally appropriate advocacy ran from November 2021 to June 2022. They aimed to “identify how to respond appropriately to the diverse needs of individuals from black, Asian and minority ethnic backgrounds”. The pilot sites recruited advocates who were themselves from ethnic minorities, were trained in mental health advocacy and legislation, and were culturally competent.

305. The Independent Review stated that the provision of culturally appropriate advocacy is “particularly important in redressing the balance for individuals of African and Caribbean heritage, who are disproportionately

impacted by broader societal inequalities”.

They recommended that it should be provided “consistently” for people of all ethnic backgrounds, but particularly for black African and Caribbean descent and heritage.

306. We heard this sentiment echoed by many of our witnesses—that the inclusion of culturally appropriate advocacy was crucial in supporting patients from ethnic minorities and addressing racial disparities in the use of the MHA. For example, in our survey responses, one respondent wrote that the fact that it had been left out of the Bill is “disastrous” and that they fear this “vital role” will be “bolted on to the current IMHA services across the country” and fail to deliver the results the Independent Review wanted. Another respondent said that patients from black and minority ethnic communities’ backgrounds need advocates from their own background so that they can trust that they will be listened to properly and understood.

307. We heard from the culturally appropriate advocacy pilot sites that the initial pilot reported positive outcomes in their qualitative responses from around 200 participants. They said that culturally appropriate advocacy contributed to ‘building trust and confidence with service users, carers, nominated persons and their networks and families’. They argued that it supported diversion from detention for individuals from ethnic minorities, and thus was preventative in nature. As Dr Jacqui Dyer from Black Thrive told us:

I cannot emphasise enough how important that attention through a culturally appropriate lens is to dealing with the differential experience that comes from structures infused with systemic racism and structural inequities, and helping to rebalance the power dynamic in the best interests of a person when they are at their most vulnerable.

308. Although the pilot has been completed, the Government told us that it “would not be right at this stage to make any provision in primary legislation”, but instead are undertaking second longer-term pilots to understand “how culturally appropriate advocacy can be delivered at a local level”. They further argue that the roll out of culturally appropriate advocacy services would not require any provisions in the Bill, and that the Code of Practice may be used instead.

309. Nonetheless, witnesses felt that the early findings were enough:

We have seen early signs of that being successful in reaching into the communities that we serve, helping to promote recovery and keeping people well and not going to hospital—or, if they do, bringing them back from discharge.

310. We also heard evidence that the resourcing and funding for culturally appropriate advocacy services would require attention. For

example, how and where local authorities would recruit people with the appropriate experience and knowledge to effectively perform the role of culturally appropriate advocate, training new advocates, as well as ensuring ongoing funding for their role. We heard that if the funds are not made available to allow advocacy to be delivered well, “that will have a major negative impact on the efficacy of what is being suggested”.

311. The type of skills, experience and knowledge required was highlighted by Dr Nahed Arafat, an interpreter and academic. This included: acknowledging the way some cultures viewed clinicians; the experiences patients may have had as refugees in the asylum system; the need to provide interpreters who understand the culture, values and religious beliefs of groups as well as being able to speak the language; and the ability to explain rights and legislation in language that it is easy for patients to understand.

312. The British Association of Social Workers warned that as the provision of culturally appropriate advocacy is not likely to happen quickly, thus “consideration must be given to the provision of such advocacy in the interim. Recognition of peer advocacy as an appropriate and relevant option would be helpful”. This was also acknowledged by the Independent Review, which stated, “the availability of peer and/or community advocacy should be substantially increased to support individuals in need of mental health support in the community”. The status and funding of such advocacy was raised by Jami, a mental health charity supporting the Jewish community:

Will registered advocates in the voluntary sector be given the same ‘weight’ as those employed in statutory services or in services commissioned by statutory grants? There are many

charities like ours, who have a growing advocacy service but are not in receipt of statutory funding or grants.

313. **Culturally appropriate advocacy is important to ensure that black and ethnic minority patients can have a greater say in their care, and is suggested to divert black people from detention under the Mental Health Act. Indeed, pilot culturally appropriate advocacy programmes have proved promising. In light of this, and given the imperative to address the large racial disparity in the application of the Mental Health Act, the Government cannot afford to miss the opportunity to include a right to culturally appropriate advocacy in the legislation now, given another legislative opportunity may not arise in the near future.**

314. ***The Bill should include a statutory right to request Culturally Appropriate Advocacy, as defined in the existing***

pilots. The Government should consider the workforce requirements needed for this change and the Impact Assessment and implementation plan should ensure adequate timing to develop services. The second round of pilots should be evaluated before commencing this right so that lessons can be learnt in its implementation.

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11 Patients concerned in criminal proceedings or under sentence

315. Patients who are concerned in criminal proceedings or under sentence come under Part III of the Mental Health Act (MHA). They include those who are subject to a compulsory measure under the MHA by the criminal courts, or who have been transferred to hospital from prison or another type of custody, for example, an immigration removal centre. They are also termed “forensic patients”.

Conditional discharge subject to deprivation of liberty conditions

316. Under current legislation, restricted forensic patients may leave hospital under a ‘conditional discharge’, if deemed appropriate by the Tribunal or the Justice Secretary. A ruling by the Supreme Court in 2018 held that under existing legislation such conditions cannot amount to a deprivation of liberty, i.e. patients being required to live at particular places which

they would not be free to leave. Following this ruling, several patients on a conditional discharge which amounted to a deprivation of their liberty were recalled to hospital or recalled and immediately placed on extended leave under Section 17 of the MHA, with clinicians using this as a 'workaround' to grant supervised leave into the community.

317. The draft Bill therefore introduces a new category of conditional discharge for restricted patients which would enable discharge with conditions amounting to a deprivation of that person's liberty, known as 'supervised discharge'. The Government suggest that this would support a small number of patients who are no longer benefiting from being detained in hospital and would benefit from 'step down' into the community, yet "due to the serious risk of harm they present to the public" this would not be possible under a current conditional discharge. They say this will be providing oversight of what is already happening, with

individuals currently being managed in the community “via long-term escorted leave (those with mental capacity) and those who have been conditionally discharged with a DoLS authorisation (those without mental capacity)”. Keeping these individuals on extended leave is particularly costly to services, as they have to keep a bed ‘open’ for the patient in hospital.

318. The Independent Review recommended that such a provision be introduced and that it should be for the Tribunal to decide on such a form of discharge. The draft Bill proposes the provision could be made by either the Secretary of State (under Section 42) or the Tribunal (under Section 73), which follows on from the current process through which someone is subject to a conditional discharge. When considering whether to apply conditions that amount to a deprivation of liberty, the Secretary of State is required to consider if they are “necessary for the protection of the public from serious harm”, whilst the Tribunal should

consider if the conditions are “necessary for the protection of another person from serious harm” and also whether the supervised discharge would be “no less beneficial to their mental health than for them to remain in hospital”.

319. This variation from the Independent Review’s recommendation has raised concerns. First, as the Secretary of State is only required to consider risk, “the new power would use the Act for public protection only, not mental health treatment”. Second, West London NHS Trust raised that although they agreed with the provision of supervised discharge, they felt clinical staff involved should have more protection through a tribunal decision:

Equally, we feel it is important that staff involved in such cases have the protection of a judicial decision to ensure that their actions for the protection of the wider public are lawful and supported.

Third, we heard how service users find the tribunal process “hard to access”, meaning they may struggle to apply themselves and not have access to this safeguard until the first automatic review.

320. The Independent Review also recommended that any provision should have an adequate level of safeguards. The draft Bill proposes that an individual on a supervised discharge may apply to the Tribunal six months from its commencement, with an automatic referral being made at 12 months if not applied for prior to this. Automatic referrals occur every two years thereafter.

321. Broadly, NHS Trusts believed this proposal is a positive development, remarking that it will enable a less restrictive environment for these relatively rare cases, as long as it has appropriate oversight by the Tribunal. NHS Providers told us they expect a positive impact in terms of length of stay for the small number

of patients for whom these new arrangements will apply. West London NHS Trust felt it would address the use of the current Section 17 leave workaround, which is “far from ideal”.

322. We have also heard concerns that supervised discharge may be used “more than expected”. We have been told two potential reasons for this: “a culture of blame” towards clinicians which risk them recommending tighter restrictions out of caution, a judgement of risk associated with certain diagnoses or where judgements of risk are conflicting between different professional groups and services. We also heard concern from multiple witnesses that this provision may be used disproportionately for black and ethnic minority patients, instead of less restrictive forms of discharge, following trends seen in the use of Community Treatment Orders (CTOs). We have heard how important it will be that data collection and analysis of the use of supervised discharge is tightly monitored to assess whether these concerns transpire.

The Government said that they are “committed to being transparent about the use of the power”.

323. Witnesses who were not supportive of the proposed supervised discharge suggested an alternative proposal to allow this small group to move into the community. They proposed that instead a ‘placement’ into community homes, which are registered as hospitals and could therefore remain under the MHA, would be a more suitable route. They argued this would enable patients to be supervised whilst moving into the community but have the safeguards for detained patients under the MHA, including that these community homes would be “subject to the same regulations and inspection requirements as secure hospitals”.

324. **We are concerned that the supervised discharge proposals in the draft Bill, which allow for a deprivation of liberty in the community for people**

with capacity, might be used more than envisaged and disproportionately against black and ethnic minority patients. We welcome the increased access to tribunals, compared to other conditional discharge, but independent oversight is needed earlier in the process. We share concerns that it may be possible to place an individual on a supervised discharge only considering their risk, without there being therapeutic benefit compared to other forms of discharge. This would be against the direction of travel seen in the rest of the draft Bill.

325. ***We recommend that there be a statutory duty to collect and publish data on the use of supervised discharges, including duration, cause and demographic profile. We recommend that there be a statutory review after three years from the commencement of the clause enabling supervised discharge***

and that the provision will expire following that review, unless renewed through approval of both Houses of Parliament.

326. Despite the Government's preference for consistency with the approach for other forms of conditional discharge, we consider that extra safeguards are necessary given that this form of discharge involves the deprivation of liberty. We recommend that the Tribunal must be involved in the decision to place someone on a supervised discharge, as recommended by the Independent Review, to ensure that therapeutic benefit is being considered in this process. This would be in line with the Principles.

327. The Government should consult with the Care Quality Commission and set out in their response to this report how community care homes or other establishments in which individuals may be residing under

supervised discharge can be appropriately regulated and inspected, relative to hospitals, considering the deprivation of liberty patients will be under.

Transfer to Hospital

328. The draft Bill introduces a statutory 28-day time limit within which relevant bodies must “seek to ensure” individuals with a severe mental health need are transferred from prison, or another place of detention such as an Immigration Removal Centre (IRC), to hospital for treatment under the Mental Health Act.

329. Good practice guidance published by NHS England and NHS Improvement currently recommends that transfers should not exceed 28 days from the point of initial referral for assessment, and as such a 28-day transfer time from prison to hospital is already sought by health and justice agencies. However, the draft Bill goes further by including this time limit within statute.

330. We have heard strong support for this proposal, and stakeholders agree that delays in transfers must be reduced. However, multiple witnesses told us that the 28-day time limit is currently not being achieved for the majority of services, one reason being the lack of appropriate beds in Psychiatric Intensive Care Units and secure care settings.

331. We also heard that the current requirement in the draft Bill that services “seek to ensure” that the transfer takes place within the time limit, is “quite vague and open”. We heard that this should be replaced with “to ensure” or “must ensure” to strengthen this provision and make it clear that it needs to happen. The Government argued “seek to ensure” was used as “no single party can independently guarantee in all circumstances that a transfer takes place within the statutory 28-day time limit, but seeks to ensure that all parties make a reasonable effort to adhere to this”. Yet, Justin Leslie, a mental health lawyer

and former Parliamentary Counsel, told us how the “exceptional circumstances” provision that is included provides a strong enough “safety valve” for when patients are unable to be moved in this time.

332. We also heard from the Government that they “are working closely with NHS England to put in place the processes to ensure that appropriate bed provision will be available ahead of operationalising these changes to account for any change in demand”. The responsible Minister, Rt. Hon. Damian Hinds MP, commented that “having a statutory requirement for transfers to be made within 28 days is quite a powerful lever” which will allow the Government to develop their healthcare provisions.

333. Additionally, the Independent Review recommended introducing a statutory, independent role to monitor and manage transfers from prisons and immigration removal centres “similar to that of AMHPs for civil patients”. They argued that this role would support the 28-day time limit as their involvement would “unblock institutional barriers” and have “the teeth it needs to push the transfer through”. The Government accepted this recommendation in the White Paper; however, no role was created in the draft Bill. We heard from the Minister that:

It is in discussion between the Ministry of Justice, colleagues from NHS England, the Prison and Probation Service and the Home Office about how best to do this oversight role. It is fair to say that there is no consensus among stakeholders about exactly where it

should sit, and having a non-statutory body gives some more flexibility in that [...]

[...] We will, of course, come forward with detail about what that means before the Bill is considered by Parliament.

334. **Whilst the statutory 28-day deadline for transfer from prison is welcome, there is already such a deadline and it is often missed. The draft Bill requires only that the relevant authorities “seek to ensure” that the deadline is met, and it is unclear how the Government will support services in achieving this deadline in future. We agree with the recommendation of the Independent Review that independent oversight is needed to protect patients’ interests in the criminal justice system and monitor timeliness against the new statutory 28-day time limit for transfers from prison and immigration removal centres to hospital.**

335. ***For the 28-day transfer deadline to be meaningful we recommend that “seek to” be removed, so that the duty is to ensure that the deadline is met. We appreciate transfers involve multiple authorities and bodies with some lenience being needed, but if included in legislation it should a meaningful deadline that can be applied to services who should be expected and supported to meet it.***

336. ***The Government should set out an action plan alongside the Bill that has a clear timeline and process for how all services will achieve this deadline.***

337. ***The Government should include the newly developed statutory independent role to monitor and manage prison transfers in the Bill when it is presented to Parliament, as stated by the Minister.***

Prisons and Police Stations

338. The draft Bill makes two further changes to the Mental Health Act aimed at reducing the number of people who are experiencing mental health difficulties and in police stations or prisons. The draft Bill removes prisons and police cells as a 'place of safety' (Clause 41), and ends remand solely based on concerns about mental health (Clause 42). These changes were welcomed, with many witnesses agreeing prison and police custody are not suitable environments for someone experiencing mental health difficulties.

339. Yet we heard that there needs to be adequate community crisis care and health-based places of safety to support these changes. We heard concerns from the CQC that "the police may choose to use criminal justice powers of arrest instead of MHA provisions, if they are concerned about whether a mentally disordered person could

be safely contained in such a health-based place of safety”. Furthermore, that this would disproportionately affect black people, as they are “disproportionately likely to access mental health treatment through the police or criminal justice routes, as their behaviour often gets identified as criminal rather than as mental distress”.

340. **We support both the changes to the Bail Act set out in the draft Bill and the removal of prisons and police cells as a place of safety. At the same time, these changes—like others—will require the provision of high-quality community care and underline the need for the implementation plan recommended in Chapter 4.**

12 Crisis Management

Emergency Departments

341. We heard concerns about a 'gap' in mental health care that occurs when individuals experiencing a crisis arrive in Accident and Emergency (A&E) Departments, yet there is no power to formally hold them. Under Section 136 of the Mental Health Act (MHA), police take an individual to a 'place of safety', which could be an A&E department or a designated Section 136 suite, and can hold them there for up to 24 hours. Section 5 allows certain staff to hold inpatients on a ward for up to 72 hours, until they can be formally assessed under the MHA. However, neither Section 5 nor Section 136 can be used by clinical staff within A&E, meaning that if an individual is awaiting either a mental health assessment, or has been assessed as needing mental health support under the MHA, they are either free to leave or held under common law powers. We are told this

becomes particularly difficult when individuals are assessed as needing urgent mental health care but are deemed to have decision-making capacity and so do not fall under the Mental Capacity Act.

342. This “gap” is exacerbated by a myriad of factors, such as long waiting times for mental health assessments, long waiting times for suitable beds, and a lack of a ‘place of safety’ in the meantime. Dr Chloe Beale, a Consultant Liaison Psychiatrist, told us that currently people in crisis are potentially being unlawfully deprived of their liberty to prevent them from harming themselves. We’ve heard an argument for the use of a power in this setting, which would simply provide a legal basis of detention and an audit trail for things that are already happening. Dr Mark Buchanan, from the Royal College of Emergency Medicine, told us that until there is a change, doctors will continue to “fudge” things because of cases:

[...] where patients unfortunately lost their life because we had not been able to keep them from leaving. That is devastating for families. It is devastating for staff. The thought of somebody they were looking after going out and ending their life is huge.

343. Alternatively, doctors raised the use of a “workaround”, where the police will be called to A&E in order to hold someone under the powers in Section 136 until they can be seen by the appropriate service. Dr Beale expressed how difficult this was:

How does that make sense? A police officer has more power in that situation than I do. How can I excuse calling the police to my department to assist in mental health care? Even if I had lots of nurses trained in restraint, we have no legal power to exercise that, but a police

officer does. We want to reduce the involvement of police in mental health care, not invite it.

This also impacts on police resources. We heard from the Metropolitan Police that where A&E can “lack the security and/or capacity to manage mental health crisis care effectively” police officers may be left supervising an individual in crisis, and so are unable to attend to crime priorities.

344. The Independent Review team shared how they struggled to find a legislative answer to this issue, but did consider extending the ‘holding’ powers for Section 5 to cover A&E. They ultimately decided that this would be increasing restrictions on an individual’s liberty by “using the MHA to respond to what are often problems of resourcing and the provision of mental health support services in the A&E environment”. In their oral evidence session, they further suggested that improving access to

crisis and Liaison & Diversion services would reduce the likelihood of individuals in crisis turning up in A&E.

345. However, the Review did recommend that proposed changes to the Mental Capacity Act (MCA) could resolve this issue for patients without capacity, as they argued against introducing “new coercive powers for people with a mental disorder”. They proposed that the new Section 4B of the MCA would allow temporary deprivation of liberty in face of an emergency, for up to 72 hours, and as such could be used here.

346. The Government agreed that it wished to “improve the powers available to health professionals in accident and emergency departments” and considered ways they may be able to increase the powers available in A&E. However, it ultimately decided against this in the draft Bill “in favour of exploring non-legislative activity to improve support for those with a

mental health crisis in A&E". They stated that this decision was informed by stakeholders, who told them that other legislation, including the Mental Capacity Act, "already provides adequate legal power to clinicians" and that any new powers may lead to a rise in detentions under the MHA, particularly for black people.

347. NHS England agreed with the Government's decision, telling us that having such a power "would be a disaster". They felt it would deter people from attending A&E, as well as permit the police to leave people in crisis in A&E. They similarly argued that increasing crisis support and Liaison and Diversion services should help provide alternatives to admission that would be more beneficial compared to increased A&E use.

348. Whilst NHS England, the Government, and others are right to suggest that this is primarily a resourcing issue, even a perfectly resourced system would not remove the

issue entirely, as there would still be people attending A&E with urgent mental health needs. Furthermore, assessment at A&E is imperative to understanding whether behavioural changes are symptomatic of serious physical health conditions, such as hypoglycaemia or sepsis. Nor would resourcing address the fact that clinicians are having to deal with the situation now, with whatever resources are available.

349. One suggestion was to introduce the use of an “emergency detention certificate”, which is used under Scottish Law, and can be issued for up to 72 hours. The Government told us that they had considered this whilst exploring what a new holding power could look like, but said it was ultimately dismissed due to the 72-hour time limit being rejected by respondents to their consultation. Furthermore, we were told about how advance choice decisions can support people who arrive at emergency

departments in crisis, which may be another way to support people to receive the help and care they need.

350. We support the development of A&E departments to provide holistic assessments of people in acute mental distress in a safe place and prescribe additional support from a home treatment team if needed. The new guidance on home assessments for the care of physically ill people and NHSE's strategy for earlier hospital discharge should be recommended for people in acute mental distress too. If home assessments deliver the quality and level of personalized support intended, then it could lead to effective supported discharge to a home or other suitable setting. Furthermore, the New Hospitals Programme could offer alternatives to traditional 'hospital at home' models of care.

351. **Many of the pressures in A&E are ultimately best tackled by clear, efficient, and adequately resourced routes**

to appropriate care for those in mental health crises. At the same time, even with these routes in place, there would still be individuals who present at A&E with symptoms of mental illness for a variety of reasons. There is a gap in the current law which may result in patients being detained unlawfully or not being treated in crisis situations. We have seen no clear reason why that gap should not be closed, although it will need to be done carefully to avoid unintended consequences.

352. *We recommend that the Government should consult further on a short-term emergency detention power, and whether this would provide greater legal clarity to clinicians and accountability for what is happening in A&E services.*

Interaction of the Mental Health Act and the Mental Capacity Act

353. We discussed in Chapter 2 the complex and sometimes problematic interface between the Mental Health Act and the Mental Capacity Act, as last amended in 2019. There are other potential gaps in mental health legislation arising particularly from this interaction and these show up particularly in crisis management situations. We pursued three of these in correspondence with the Government and this subsection sets out what we found.

354. Firstly, according to the draft Code of Practice, the emergency power in Section 4B of the MCA (referred to above) will not cover the period of referral for assessment under Section 2 of the MHA before the application is completed, so that in cases where someone needed to be detained during this period, the police would need to be brought in to use their

Section 136 powers, or some other workaround may have to be found. These options may be inappropriate, impracticable, or unlawful.

355. Secondly, the draft Code of Practice also takes the position that Liberty Protection Safeguards of the Mental Capacity Act will not apply where someone detained under the MHA needs detaining for treatment for something else, such as a physical condition. A hospital would need to go to court to enable treatment in such circumstances. The Government gave no reason why the expense and added time taken by a court application is justified in these circumstances.

356. Thirdly, in determining whether a patient falls within scope of the MHA or the MCA in certain circumstances, there is a subjective test of whether the patient “objects” to accommodation or treatment under the MHA (despite difficulties determining whether a

person without capacity may “object”), whereas elsewhere an objective test is used. It is unclear what the reason for the difference is.

357. ***The Government should look to resolve the three gaps or ambiguities in the law regarding the interface of the Mental Health Act and the Mental Capacity Act identified in this subsection, through amendment of the Mental Capacity Act if necessary. Such relatively minor changes could make a significant difference to simplifying decision-making in difficult circumstances, without prejudicing the rights of the patients concerned.***

358. ***Our inquiry has highlighted the complexity and unintended consequences of the interface between the Mental Health Act and Mental Capacity Act. This issue needs to be addressed. We recommend that the Government review the interaction between the two pieces of legislation as part of the***

process of ongoing reform recommended earlier in this report. In particular, it should review the use of the Mental Capacity Act to authorise admission to, and treatment in, mental health units.

Places of Safety

359. Under the current Mental Health Act, those detained by the police or otherwise under the criminal justice system can be taken to health-based places of safety, but a small number may be detained in prison or police custody. The draft Bill removes prisons and police cells as “places of safety”. There has been wide support for this change, along with agreement that police cells or prison are the wrong place for people in a mental health crisis.

360. The Independent Review recommended that prisons and police cells should be removed as ‘places of safety’, but further commented on the need for improvements within Section 136 health-based suites in supporting this change.

Furthermore, we have heard about the lack of Section 136 suites, meaning that individuals in crisis end up in the care of emergency departments, as we discussed in the previous section of this chapter.

361. We also heard concerns that due to the lack of Section 136 suites patients may continue to be held by the police, or arrested, if the police are “concerned about whether a mentally disordered person could be safely contained in such a health-based place of safety”. Additionally, the Lived Experience Advisory Board at King’s College London highlighted that this unintended pathway would disproportionately impact black and ethnic minority individuals, as they are more likely to access mental health treatment through the police or criminal justice system.

362. The Metropolitan Police told us it was not appropriate for patients to be under the supervision of police officers as they “do not

have the specialist training to best manage mental health crisis”, and that being left with an officer can “exacerbate mental health crisis”. We heard similarly from Alexis Quinn, an autistic woman, about her difficulties being picked up by the police whilst in distress. However, she did highlight that when she had a ‘flag’ attached to her records to indicate her association with mental health services, “they handled it very differently and brought me back”, rather than taking her to an inappropriate place of safety.

363. NHS England and NHS Digital have built a national record of a ‘Reasonable Adjustment Flag’, which indicates that reasonable adjustments are required for an individual, as well as having an option to include specific details of any impairments or key adjustments that should be considered. This Flag is part of the ‘NHS Spine’; an IT infrastructure which joins together healthcare systems across multiple organisations in England. This enables health and care

professionals to record, share, and view details of reasonable adjustments across the NHS. This Flag is being developed in line with the NHS Long Term Plan, which requires a 'digital flag' in patient records be available by 2023/24 to ensure staff know a patient has a learning disability or autism. NHS England have completed the first phase of pilots and expect following technical updates and a second pilot at the end of 2022, the capability will be made available for wider use.

364. ***The provision of appropriate places of safety will be crucial to reducing detentions and reducing the pressures on A&E and police services, especially following the welcome removal of prisons and police custody as places of safety. We recommend that the Government increases the provision of appropriate health-based places of safety, and include plans for this within the implementation plan recommended in Chapter 2.***

365. ***We recommend that all people known to a mental health service with a known learning disability and/or autism should have the reasonable adjustment flag attached to their record, with an option for individualised adjustments of preferred communication and the name of their advocate.***

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13 Conclusion

366. During this inquiry we have heard concerns about how the reforms proposed in the draft Bill will play out in practice. We have heard again and again about the importance of proper implementation, resourcing, access to community alternatives to hospital and the need to take account of possible unintended consequences. These concerns should not take away from the broadly positive response to the draft Bill or the sense of urgency about introducing some of its reforms. Our recommendations are intended to strengthen the draft Bill, to address some of those unintended consequences and to ensure transparency and accountability about implementation. If the Government is willing to strengthen the draft Bill in the ways we have suggested it can make an important and necessary contribution

**to addressing the problems that the
Independent Review was established to
consider.**

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Conclusions and recommendations

Introduction

1. *To facilitate early engagement with future pre-legislative scrutiny, we recommend that the Cabinet Office's Guide to Making Legislation include wording for Bill Teams to include in press notices announcing future draft Bills. This should advise readers on the upcoming scrutiny process and direct them to where further information can be found. This wording should be agreed with officials in the Scrutiny Unit in both Houses of Parliament. (Paragraph 8)*

Overall Approach

2. The draft Bill has been widely welcomed by those we heard from during our inquiry. It contains important reforms developed, for the most part, over more than five years through a consensual process involving professionals, service users, the Government

and Independent Review team. We welcome the draft Bill and would like to see it introduced in this Session of Parliament. (Paragraph 23)

3. The Mental Health Act 1983 is nearly forty years old. It has been amended multiple times over those years, making it hard to use even for experienced professionals. It is overly complex, especially where it interacts with the Mental Capacity Act 2005. It is focused on coercive powers rather than patients' rights. The draft Bill with our proposed amendments will help, but it should not be the end—or even a pause—in the process of reform of mental health legislation. (Paragraph 24)

4. *We recommend that there should be an ongoing process of mental health legislation reform, leading in the direction of more “fused” and rights-based legislation and learning from developments elsewhere in the*

UK and overseas. In advance of this work, the Government should look for opportunities to amend the Code of Practice to improve the justification required for clinical decisions to use the Mental Health Act where a patient has decision making capacity and is refusing admission and treatment. (Paragraph 25)

5. *Effective handling of complaints is an important part of ensuring patients feel their voices are heard and services improve from a service user perspective. We recommend that the Government adopt the Parliamentary and Health Service Ombudsman's recommendations on streamlining and signposting complaints processes.*

(Paragraph 30)

6. Patient choice and advocacy has been central to the Independent Review and the draft Bill. We were struck during our inquiry that there is no independent figure to advocate on behalf of those who are

detained or are likely to be detained under the Mental Health Act or their families and carers. Such statutory roles exist in other fields, for example the Children's and Victim's Commissioners. We see advocacy as especially important to challenge the stigma that still attaches to mental illness and the Mental Health Act, especially in relation to severe and enduring conditions such as schizophrenia. Such an advocate would be well placed to ensure that the process of reform does not end with this draft Bill. (Paragraph 31)

7. *We recommend that the post of a statutory Mental Health Commissioner and should be created, with the support of an Office. Their role should include:*

- a) *Being a voice at the national level promoting the interests of those who are detained, or are likely to be detained, under the Mental Health Act, and of their*

families and carers, raising awareness of their needs, and challenging stigma and stereotypes;

- b) Working in conjunction with the Care Quality Commission and other bodies to make recommendations on reforming mental health law in the direction of more rights-led and “fused” legislation;*
- c) Tracking the implementation of the reforms in and associated with this Bill, including the provision of data;*
- d) Providing advice and support to service users, their families and carers on their rights and how to navigate complaints processes; working with NHS bodies, the Care Quality Commission and Parliamentary and Health Service Ombudsman to promote best practice in handling complaints.*

We see the role of the Commissioner being primarily to act as a watchdog to oversee

the direction of travel for the key reforms of the MHA, cognisant of the associated risks we highlight in this report relating to funding, implementation and unintended consequences. In addition, they would monitor outcomes and cultural changes which we hope will result from these reforms. We recommend further functions for this role in Chapter 3 around inequalities and data. (Paragraph 32)

8. The Independent Review's four Principles have been arrived at following an extensive and consensual process lasting nearly half a decade. We want to see them in primary legislation, as opposed to a Code of Practice, so that they cannot simply be replaced or withdrawn by a future Secretary of State, to ensure they inform how the amended Act operates in practice, and to be a legal and symbolic driver for the cultural change that the draft Bill is trying to bring about. (Paragraph 39)

9. *We recognise the Government's concerns about putting entirely new Principles into the Mental Health Act and are wary of making complex legislation yet more complex. We believe that there already exists a mechanism to put the Principles into the Act that meets those concerns. We recommend that Section 118 be replaced with a new Section, requiring the Secretary of State to draw up the Code of Practice having regard to and including the Principles set out in the Independent Review: choice and autonomy, least restriction, therapeutic benefit and the person as an individual. The new Section should also specify that the Principles should inform decisions taken under the Act, mirroring the current wording in Section 118. This would ensure that the Principles endure, inform the operation of the amended Act and would require the Government to ensure they*

are reflected in the practical guidance given to professionals on all aspects of how the Act operates in practice. (Paragraph 40)

10. *We recommend that the replacement for Section 118 be placed at the beginning of the amended Act. This would reflect the central role of the Principles and Code of Practice in the operation of the Mental Health Act in practice. It would make the legislation more accessible and better tell the story of what the amended Act is trying to achieve. Placing principles relating to patient choice and least restriction in the legislation before the powers to detain is logical and would send a message to help drive that cultural change ahead of more fundamental reform. (Paragraph 41)*

Racial Inequalities

11. The Independent Review was established to address racial and ethnic inequalities in the application of the Mental Health Act.

Five years on these have not improved and, on some key metrics, are getting rapidly worse. This is a collective failure that is unacceptable and inexcusable. The draft Bill must be stronger in how it tackles racial disparity. (Paragraph 56)

12. *The principles that the Secretary of State is required to draw up under Section 118 of the Mental Health Act that “inform” decisions under the Act do not explicitly include the need to respect racial equality. Whether or not they accept our earlier recommendation about re-writing Section 118, the Government should amend it so that the list of matters that the Secretary of State must address in the Code of Practice includes respect for racial equality.* (Paragraph 57)

13. *Improving data collection will be an important part of reducing inequalities, but it cannot be an excuse for a lack of urgent and comprehensive action. There should*

be a responsible person for each health organisation whose role will be to collect and monitor data on the number, cause, and duration of detentions under the MHA broken down by ethnicity and other demographic information. The Secretary of State must ensure that these statistics are published at the end of each year. (Paragraph 58)

14. *The Responsible Person should also oversee workforce training and policies designed to address bias and discrimination in decision making in the operation of the Mental Health Act on the basis of protected characteristics, including the implementation of the Patient and Carer Race Equality Framework (PCREF). (Paragraph 59)*

15. *We recommend that one of the roles of the Commissioner proposed in Chapter 2 will be to be a national figure overseeing, standardising, and promoting the work of the 'Responsible People' proposed above*

and already in the Mental Health (Use of Force) Act. They should also work with NHS and independent services, the Care Quality Commission, Equality and Human Rights Commission and the Office of the National Data Guardian, to produce proposals aimed at reducing inequalities in, and improving data on, the provision of services and use of powers under the Mental Health Act.
(Paragraph 60)

16. *The Government should work with NHS England to produce an implementation plan for the NHS's non-legislative programmes to address inequalities in mental health care with clear milestones and reporting against them. Examples of milestones might include appointment of 'Responsible People', take up and implementation of the Patient and Carer Race Equality Framework, increased awareness of the public sector equality duty, reductions in disproportionate detention rates, improved diversity in the workforce*

and access to culturally appropriate advocacy, which is discussed later in this report. (Paragraph 61)

17. *The evidence shows that Community Treatment Orders (CTOs) are being used more than intended and, in many cases, as a more restrictive alternative to discharge. There is not enough evidence to demonstrate benefit for the use of CTOs for Part II patients to justify their continued use, especially as they are used disproportionately for black and ethnic minority patients. We recommend that CTOs are abolished for patients under Part II of the Mental Health Act. (Paragraph 68)*

18. *We have received some evidence that suggests unrestricted Part III patients may benefit from CTOs. However, that evidence is inconclusive, so we recommend that the Government should amend the draft Bill to*

include a statutory review of CTOs for Part III patients, to report within three years of Royal Assent. (Paragraph 69)

19. *We also recommend that the Bill contains a provision that abolishes CTOs for Part III patients six months after the time for the statutory review recommended above expires (or earlier with the approval of both Houses of Parliament). This would give the Government time to introduce legislation to stop the abolition of CTOs for Part III patients if the statutory review demonstrated convincingly that they had value and were now being used in a non-discriminatory way. If that were not the case, they would be abolished automatically without need for further legislation. (Paragraph 70)*

Resourcing and Implementation

20. **Successful implementation of this legislation should result in a transformational impact on mental health services, reducing**

pressures on inpatient services. However to achieve this it will need adequate funding and workforce provision. We have heard scepticism about the existing implementation plans in our evidence. Without adequate resourcing, the reforms may divert resources from services that are already under intense pressure or prove to be ineffective. (Paragraph 95)

21. *We recommend that the introduction of the final Bill should be accompanied by a revised impact assessment to take account of changes in the workforce and the economy since the original was published. It should also be explicit about the extent of interdependencies with other Government programmes and policies.* (Paragraph 96)

22. *The Government should publish a comprehensive implementation and workforce plan alongside the Bill. It should contain clear actions and key milestones*

detailing the implementation of the Bill and how they link to milestones in the implementation of the 10 Year Plan and other relevant Government policies. These should include milestones on workforce development, training, advocacy and community care capacity, as well as on numbers of detentions, length of stay and reducing racial and ethnic inequality. There should be a statutory duty to report annually to Parliament on the progress against these milestones during the implementation period. (Paragraph 97)

Detention Criteria

23. We reiterate the conclusion of our previous chapter that the changes in detention criteria, as with the draft Bill as a whole, need to be supported with adequate and accessible community-based alternatives to detention if they are to be successful. (Paragraph 118)

24. *We were disturbed by the evidence we received that the concept of “capacity” has been misused to deny treatment to very ill and potentially suicidal patients when they have voluntarily sought it. We recommend that the Government set out in the response to this Report what it, the CQC and NHS Trusts are doing and will do to prevent this practice. (Paragraph 119)*

25. *We welcome the Government’s confirmation that there will be further guidance on applying the new detention criteria in the Code of Practice. We recommend that this particularly address the definition of “serious” harm and give guidance on how the “likelihood” of harm should be assessed. This should balance the need to ensure detention is a last resort with the potentially greater therapeutic benefits of an earlier intervention in some cases. It should be clear that the changes in criteria should not be used to deny care to those who need it*

and would benefit from it, including where serious harm would arise from a breakdown in personal circumstances, health neglect or deterioration. (Paragraph 120)

26. *We recommend that the consideration of “how soon” harm might occur should not be included in the draft Bill itself. This was not in the Independent Review’s recommendation and would be better handled in the Code of Practice. Whilst we recognise what the Government is trying to achieve, it will be difficult for professionals to assess objectively. We are concerned that it might dissuade potentially beneficial and shorter interventions at an earlier stage that would be in keeping with the Principles. We recognise that some witnesses saw this provision as tackling the very real issue of long-term detentions of questionable benefit, but believe that these are already, and more*

effectively, addressed under other provisions in the draft Bill, such as increased reviews by tribunal. (Paragraph 121)

27. We recommend that the Code of Practice also give guidance on how the definition of “appropriate treatment” should be interpreted in cases with a relatively low chance of improvement, or where resourcing means treatment may not be immediately available. It should also make clear that “appropriate treatment” includes non-drug-based treatment. (Paragraph 122)

28. At present the changes in the draft Bill mean it may be easier to be detained under Part III of the Mental Health Act, which deals with those who are in the criminal justice system, compared to Part II, which covers the rest of the population. We have heard convincing evidence that this is difficult to justify on the grounds of risk and that it could result in an increase in black people, autistic

people, and people with learning disabilities being detained under Part III of the Act. This would be contrary to the aims of the Review and the draft Bill. We recommend that the changes in detention criteria should be consistent for individuals under either Part II or Part III of the MHA. (Paragraph 130)

Learning disabilities and Autism

29. We welcome the direction of travel evidenced by this legislation. Too many people with learning disabilities or autistic people have been detained in unsuitable facilities, and for too long. The draft Bill's proposed changes to the detention criteria in Section 3 are likely to improve outcomes for this group in the long term. At the same time if these changes are implemented too soon, or without the appropriate community alternatives in place, they could prove counterproductive. A staged approach to these reforms is necessary to allow time for investment in community

services and to test the hypothesis that increasing these services will allow the care system to deal with this group of individuals effectively in the community, including in crisis situations. (Paragraph 176)

30. Additionally, evidence we heard suggested that the proposed changes may actually increase the risk of people with learning disabilities or autistic people being detained under the Mental Capacity Act or through the criminal justice system instead. In both cases this could mean longer periods of detention, with fewer legal safeguards. We were also told that there is a risk that people with learning disabilities or autistic people with complex needs will be given an alternative mental health diagnosis to justify longer-term detention, which may direct them away from the care that they need. Steps must be taken to mitigate these risks in addition to the development of community services. (Paragraph 177)

31. *We recommend that the Government conducts a review of the Building the Right Support Action plan in light of the proposals in the draft Bill. It should identify which milestones in this plan must be met to ensure that people with learning disabilities and autistic people who would have been eligible for detention under Section 3 can be supported to live in the community. This review process should include all relevant parties, including service providers and service users. The milestones outlined in this review must then be met before commencement of those parts of the Bill that remove learning disabilities and autism as a condition for which people can be detained under Section 3. (Paragraph 178)*

32. *The Government must monitor outcomes for people with learning disabilities and autistic people who are no longer eligible for detention under Section 3. This monitoring should specifically focus on people detained*

under the Mental Capacity Act or in the criminal justice system, including people detained in long term segregation. The Government should commit to act if detention by these routes rises. (Paragraph 179)

33. *We recommend there should be provision by which detention can be continued after the 28-days allowed under Section 2 of the Mental Health Act for people with learning disabilities or autistic people in tightly defined exceptional circumstances. This should only be available if pre-authorized by a specialist Tribunal comprising individuals with an understanding of learning disabilities or autism. The time-period should be determined in the Tribunal and subject to regular review by the same Tribunal. The conditions which constitute “exceptional circumstances” should be defined in the Code of Practice; we envisage they might*

include particularly complex presentations where further assessment beyond 28 days is needed. (Paragraph 180)

34. *The Government should urgently review the operation of the Mental Capacity Act in this context with a view to amending the Deprivation of Liberty Safeguards (soon to be Liberty Protection Safeguards) so they cannot be used as an alternative route to the Mental Health Act to deprive people with learning disabilities or autistic people of their liberty in inpatient mental health units for lengthy periods of time and thereby undermine the intention of this Bill. We reflect that this would be a specific disorder exclusion from the Liberty Protection Safeguards, which have not yet been put into practice. We also recommend that the Government re-examine the inclusion of other specific disorders under the LPS in this context in future, for example, dementia. (Paragraph 181)*

35. *If the Government decides to accept our recommendation to make the changes to the detention criteria for Part II and III the same, it will be imperative that it follows through with existing plans to provide enhanced diagnosis, care and treatment for people with learning disabilities and autistic people in prisons. The reviewing requirement outlined above should explicitly include milestones in this regard. If the Government continues with the provisions as they are in the draft Bill, with learning disabilities or autism removed as grounds for detention under Part II but not Part III of the Mental Health Act, it will be imperative that the Government develops safeguards to prevent further inappropriate use of Part III for this group. (Paragraph 182)*

36. The duty for the responsible commissioner and the appropriate Integrated Care Board to 'have regard to' the recommendations set out in the report produced following a Care (education) and treatment review

is not strong enough to ensure that the recommendations are effectively acted upon. This is likely to be particularly a problem with those local authorities and Integrated Care Boards who do not currently engage with the process. (Paragraph 190)

37. *The Government should strengthen the wording of the duty for Integrated Care Boards and Local Authorities, which currently only requires that they ‘have regard to’ recommendations in the Care (education) and treatment review reports, to ensure that the outcome of each Review is actioned effectively. This could be done either by requiring that Integrated Care Boards and Local Authorities must “follow” recommendations in the reports or by placing an additional requirement that the Integrated Care Boards and Local Authority must provide a “good reason” for not following recommendations in the reports.*

For example, that the recommendations are not in the best interests of the individual.

(Paragraph 191)

38. *The maximum time period between Care (education) and treatment reviews is too long, especially when recognising the detrimental effects that inpatient environments can have on people with learning disabilities and autistic people, particularly those who are under 18. The maximum time period between reviews should be shortened from twelve to six months.* (Paragraph 192)

39. Given the Government's intention in this draft Bill to enable more people with learning disabilities and autistic people to be cared for in the community, it is imperative that there are not only sufficient community services for this group, but a strong enough requirement on the relevant bodies to collaborate in the provision of community care. We note that this may require additional funding to ensure

sufficient and equal provision across the country but expect that these requirements can be met if the Government meets its ambitious goals for investment in community services. (Paragraph 207)

40. In particular, one consequence of this group being removed from Section 3 is that they will effectively lose access to Section 117 aftercare. This would be counter-productive to the Government's intention of providing care in the community if no equivalent duties on commissioning services to provide care for this group were introduced in its place. (Paragraph 208)

41. *We recommend that the 'risk register' is renamed 'Dynamic Support Register' in the draft Bill to better reflect its purpose. The Government should also consult with people with learning disabilities and autistic people to see how they can build trust in this mechanism.* (Paragraph 209)

42. *We recommend that the Government should strengthen the duties on Integrated Care Boards and Local Authorities to impose a firm duty to ensure the adequate supply of community services for people with learning disabilities and autistic people, using information gathered from the Dynamic Support Register. (Paragraph 210)*

43. *The duty on Integrated Care Boards to “establish and maintain” a register should be strengthened to include more proactive language, for example, using the “develop and maintain” duty in existing NHS policy for Dynamic Registers. We also recommend that the factors to be set out by the Secretary of State to indicate that an individual is at risk of admission have sufficient clarity to avoid the misinterpretation of risky behaviour as risk of admission, and to give clarity to individuals on the register and their families. (Paragraph 211)*

44. *Section 117 aftercare, proportionate to need, should also be extended to patients who are admitted under the “exceptional circumstances” route recommended above. (Paragraph 212)*

45. *The Government should commission research into the likely costs and benefits of extending aftercare, proportionate to need, to patients who are detained in mental health settings under provisions other than Section 3 of the Mental Health Act, including those admitted for more than 28 days or detained under the Liberty Protection Safeguards of the Mental Capacity Act. Informed by this research, the Government should consider extending Section 117 aftercare, or an equivalent aftercare provision, where appropriate. (Paragraph 213)*

Children and Young People

46. *Children and young people have special needs in mental health services due to their*

age. It is imperative that these reforms do not leave children and young people behind, and that they are guaranteed the access to safeguards and treatment that they need. The provisions in the draft Bill rely heavily on consent, capacity and competence to make decisions. This is an area where the law is complex and, we heard, in need of better definition. A statutory test to assess child capacity is necessary to clarify this process for children, families, and clinicians. (Paragraph 221)

47. *The Government should consult on the introduction of a statutory test for competency, or “child capacity”, for children under 16. This consultation should be wide ranging and consider the wider implications of this reform on other areas of law affecting children.* (Paragraph 222)

48. Increasing numbers of children and young people are finding themselves in need of

mental health services. It is unacceptable that, despite reforms dating as far back as 2007, children and young people are still, and increasingly, being detained in settings that are not appropriate for their age. As more children and young people come into contact with mental health systems it is imperative that there are enough specialist services to ensure that they are given the care that they need. (Paragraph 231)

49. *The Government must take the opportunity of this legislation to strengthen the protections in the Mental Health Act against children and young people being placed in inappropriate settings, such as adult wards or placements out of area. For example, the draft Bill must amend duties on hospital managers to ensure that there are sufficient services for children and young people, and there must be stronger procedural requirements where inappropriate placements are considered, including a requirement that such a*

placement is demonstrably in the child's best interests. It is imperative that these reforms coincide with developments in the provision of specialist services for children and young people to address the core driver of this problem. (Paragraph 232)

Patient Choice

50. We welcome the introduction of statutory Care and Treatment Plans. We have heard a lot of evidence that these can be strengthened by also including statutory advance choice documents. We heard that these can be highly effective in improving outcomes such as reducing detention and increasing the efficacy of treatment by involving the patient more fully in their overall treatment, care and life decisions prior to them becoming unwell. However, for them to have the potential to do so, research

suggests patients must be meaningfully involved in the creation of the advanced choice document. (Paragraph 253)

51. *We recommend that there should be a statutory right for patients who have been detained under the Mental Health Act to request an advance choice document be drawn up. These should also be offered to everyone who has previously been detained, as recommended by the Independent Review. This provision should extend to people with learning disabilities or autistic people who have been detained under the MHA, including Section 2, Section 3 prior to the commencement of the changes in the draft Bill, and the ‘exceptional circumstances’ route outlined in paragraph 180. They should be recorded in a way that is accessible digitally, linked to a patients’ GP records, and usable quickly in crisis settings, including by first responders such as the police and paramedics.* (Paragraph 254)

52. *We heard evidence that when the patient is meaningfully involved in the creation of their ACD this helps build trust. Therefore, we recommend that to facilitate such involvement this should be done with the support of a trained person who is independent of the service users' treatment team.* (Paragraph 255)

53. Although the draft Bill does not include the ability to appeal treatment decisions to a tribunal, it does propose other measures, detailed elsewhere in this report, that would increase the frequency of appeals to tribunals. We heard a lot of evidence about concerns that such an increase would have a serious impact on the workload of mental health professionals. As such we are mindful that in recommending the inclusion of this measure, we must do so in a manner that allows for mitigation against any further increase in workload in as far as this is possible. (Paragraph 261)

54. The draft Bill does not include the Independent Review's recommendation that treatment decisions may be referred to a tribunal. We have heard that such a measure would strengthen the patient's voice. However, we recognise the concerns about the potential conflict between clinicians and tribunal judges, and about the potential increase in workload for medical professionals. (Paragraph 262)

55. *We agree with the Independent Review that a slimmed down Mental Health Tribunal should be able to consider whether a patient is entitled to challenge their treatment plans, if requested, following a Second Opinion Authorised Doctor review of their care and treatment plan or a major change in treatment. We recommend that the Government amend the draft Bill to allow for pilots in the first instance, to ensure that*

the additional workload is manageable and the Tribunal and clinicians' roles are not compromised. (Paragraph 263)

Nominated Persons

56. The Nominated Persons provisions for adults are welcome, necessary and reflect the Principle set out in the Independent Review to support patient choice and autonomy. We recommend that the Government work with Approved Mental Health Professionals to revise the proposals to address the practical concerns that have been raised with us and ensure the benefits of these reforms as envisaged by the Independent Review materialise. (Paragraph 270)

57. There will be benefits for service users and professionals if as many people as possible nominate their Nominated Persons in advance of a crisis situation. Earlier in this report we recommended a statutory right to request an advance choice document. We

recommend that the choice of Nominated Person is included in such documents. We also envisage that as part of the Mental Health Commissioner's advocacy and support function, they may wish to promote the value of specifying a Nominated Person at or soon after the point of diagnosis.

(Paragraph 271)

58. It is important that people who are eligible for detention under the Mental Health Act have access to the important provision of being able to choose a Nominated Person. Whilst welcome, extending this right to children and young people is not necessarily simple. We note with concern that some potential conflicts with the Children's Act 1989 do not appear to have been fully thought through and are surprised that this was not addressed by the relevant departments before reaching our Committee. We welcome

the Government's commitment to look again and explore the issues that we have raised. (Paragraph 278)

59. *The Government should consult specifically on how Nominated Person provisions will apply to under 18s in regard to potential conflicts with other legislation affecting children, such as the Children Act 1989. It should come forward with new proposals on how the Nominated Person provisions will apply to under 18s at an early stage in the Bill's progress.* (Paragraph 279)

Advocacy

60. *We welcome the "opt-out" advocacy scheme for detained patients. Once capacity has been built up in the advocacy sector, as measured against the annual Independent Mental Health Advocate workforce modelling targets in the Impact Assessment, it should be extended to include informal (voluntary) patients as well. This would bring particular*

benefits to children and young people, most of whom are informal patients. The Bill should include the powers to do this, to be commenced only once capacity exists to support informal patients on top of those who have been detained. (Paragraph 295)

61. We heard evidence that for advocacy to be truly effective, people with learning disabilities and autistic people would require specialist services, as would children and young people. We also heard that such services would be delivered most effectively if they were commissioned on a centralised basis for England. (Paragraph 301)

62. *There are shortages of advocates with the specialist knowledge of learning disabilities and autism, relevant language skills or cultural knowledge to support patients with specific needs. The Government should examine the case for a Central Advocacy*

Service, to meet the needs of specific groups who may otherwise go unsupported in some areas. (Paragraph 302)

63. Culturally appropriate advocacy is important to ensure that black and ethnic minority patients can have a greater say in their care, and is suggested to divert black people from detention under the Mental Health Act. Indeed, pilot culturally appropriate advocacy programmes have proved promising. In light of this, and given the imperative to address the large racial disparity in the application of the Mental Health Act, the Government cannot afford to miss the opportunity to include a right to culturally appropriate advocacy in the legislation now, given another legislative opportunity may not arise in the near future. (Paragraph 313)

64. *The Bill should include a statutory right to request Culturally Appropriate Advocacy, as defined in the existing pilots. The*

Government should consider the workforce requirements needed for this change and the Impact Assessment and implementation plan should ensure adequate timing to develop services. The second round of pilots should be evaluated before commencing this right so that lessons can be learnt in its implementation. (Paragraph 314)

Patients concerned in criminal proceedings
or under sentence

65. We are concerned that the supervised discharge proposals in the draft Bill, which allow for a deprivation of liberty in the community for people with capacity, might be used more than envisaged and disproportionately against black and ethnic minority patients. We welcome the increased access to tribunals, compared to other conditional discharge, but independent oversight is needed earlier in the process. We share concerns that it may be possible

to place an individual on a supervised discharge only considering their risk, without there being therapeutic benefit compared to other forms of discharge. This would be against the direction of travel seen in the rest of the draft Bill. (Paragraph 324)

66. *We recommend that there be a statutory duty to collect and publish data on the use of supervised discharges, including duration, cause and demographic profile. We recommend that there be a statutory review after three years from the commencement of the clause enabling supervised discharge and that the provision will expire following that review, unless renewed through approval of both Houses of Parliament.* (Paragraph 325)

67. *Despite the Government's preference for consistency with the approach for other forms of conditional discharge, we consider that extra safeguards are necessary given*

that this form of discharge involves the deprivation of liberty. We recommend that the Tribunal must be involved in the decision to place someone on a supervised discharge, as recommended by the Independent Review, to ensure that therapeutic benefit is being considered in this process. This would be in line with the Principles. (Paragraph 326)

68. *The Government should consult with the Care Quality Commission and set out in their response to this report how community care homes or other establishments in which individuals may be residing under supervised discharge can be appropriately regulated and inspected, relative to hospitals, considering the deprivation of liberty patients will be under. (Paragraph 327)*

69. *Whilst the statutory 28-day deadline for transfer from prison is welcome, there is already such a deadline and it is often*

missed. The draft Bill requires only that the relevant authorities “seek to ensure” that the deadline is met, and it is unclear how the Government will support services in achieving this deadline in future. We agree with the recommendation of the Independent Review that independent oversight is needed to protect patients’ interests in the criminal justice system and monitor timeliness against the new statutory 28-day time limit for transfers from prison and immigration removal centres to hospital. (Paragraph 334)

70. *For the 28-day transfer deadline to be meaningful we recommend that “seek to” be removed, so that the duty is to ensure that the deadline is met. We appreciate transfers involve multiple authorities and bodies with some lenience being needed, but if included in legislation it should a meaningful deadline that can be applied to services who should be expected and supported to meet it.* (Paragraph 335)

71. *The Government should set out an action plan alongside the Bill that has a clear timeline and process for how all services will achieve this deadline. (Paragraph 336)*
72. *The Government should include the newly developed statutory independent role to monitor and manage prison transfers in the Bill when it is presented to Parliament, as stated by the Minister. (Paragraph 337)*
73. We support both the changes to the Bail Act set out in the draft Bill and the removal of prisons and police cells as a place of safety. At the same time, these changes—like others—will require the provision of high-quality community care and underline the need for the implementation plan recommended in Chapter 4. (Paragraph 340)

Crisis Management

74. Many of the pressures in A&E are ultimately best tackled by clear, efficient, and

adequately resourced routes to appropriate care for those in mental health crises. At the same time, even with these routes in place, there would still be individuals who present at A&E with symptoms of mental illness for a variety of reasons. There is a gap in the current law which may result in patients being detained unlawfully or not being treated in crisis situations. We have seen no clear reason why that gap should not be closed, although it will need to be done carefully to avoid unintended consequences. (Paragraph 351)

75. We recommend that the Government should consult further on a short-term emergency detention power, and whether this would provide greater legal clarity to clinicians and accountability for what is happening in A&E services. (Paragraph 352)

76. The Government should look to resolve the three gaps or ambiguities in the law

regarding the interface of the Mental Health Act and the Mental Capacity Act identified in this subsection, through amendment of the Mental Capacity Act if necessary. Such relatively minor changes could make a significant difference to simplifying decision-making in difficult circumstances, without prejudicing the rights of the patients concerned. (Paragraph 357)

77. Our inquiry has highlighted the complexity and unintended consequences of the interface between the Mental Health Act and Mental Capacity Act. This issue needs to be addressed. We recommend that the Government review the interaction between the two pieces of legislation as part of the process of ongoing reform recommended earlier in this report. In particular, it should review the use of the Mental Capacity Act to authorise admission to, and treatment in, mental health units. (Paragraph 358)

78. *The provision of appropriate places of safety will be crucial to reducing detentions and reducing the pressures on A&E and police services, especially following the welcome removal of prisons and police custody as places of safety. We recommend that the Government increases the provision of appropriate health-based places of safety, and include plans for this within the implementation plan recommended in Chapter 2. (Paragraph 364)*

79. *We recommend that all people known to a mental health service with a known learning disability and/or autism should have the reasonable adjustment flag attached to their record, with an option for individualised adjustments of preferred communication and the name of their advocate. (Paragraph 365)*

Conclusion

80. During this inquiry we have heard concerns about how the reforms proposed in the draft

Bill will play out in practice. We have heard again and again about the importance of proper implementation, resourcing, access to community alternatives to hospital and the need to take account of possible unintended consequences. These concerns should not take away from the broadly positive response to the draft Bill or the sense of urgency about introducing some of its reforms. Our recommendations are intended to strengthen the draft Bill, to address some of those unintended consequences and to ensure transparency and accountability about implementation. If the Government is willing to strengthen the draft Bill in the ways we have suggested it can make an important and necessary contribution to addressing the problems that the Independent Review was established to consider. (Paragraph 366)

Appendix 1: Survey results

1) The Committee released a survey in August 2022, and an easy-read survey in September 2022. We received over one hundred responses. The survey consisted of fourteen multiple choice questions and a free text box for comment. The free text comments are summarised anonymously in the paragraphs below, and the questions are represented in the charts following.

Text responses

2) We heard from the survey respondents that the Bill promotes the rights of people with a mental illness and is generally a “step in the right direction”. However, we also heard that mental health care and particularly community care services would need considerable investment to ensure that the reforms will be effective. This needs to be accompanied, we heard, by a significant cultural shift to refocus on the needs and wishes of the patients. One

respondent who identified as a mental health professional said that such change will require discussion around the country involving mental health professionals and patients.

3) We also heard that the principles established by the Independent Review were widely welcomed as reflecting and promoting current best practice and should be inserted into the Bill to ensure that this change happens. One respondent who identified as having received care as an inpatient and outpatient commented that the language of the legislation is still very difficult to interpret.

Detention criteria

4) Several respondents expressed concern about the changing criteria for detention, especially the change from broad subjective tests of appropriateness to 'serious harm'.

One respondent, who had previously received mental health care as an inpatient, noted that the threshold for admission is already very high

and that this change would make it impossible for most people to access hospital care. Another respondent said that there is already “inpatient treatment gatekeeping” with patients “only being considered for admission if they are sectioned”. They said that this Bill will reduce admissions further and cause more harm. One mental health practitioner said that “raising the risk level may result in some very unwell people being denied appropriate inpatient care leading to longer inpatient stays being needed to treat entrenched illness”. Another respondent who identified as a friend, family member or unpaid carer of a person with a mental health condition said:

Including criteria of ‘serious harm’ will make it even harder for people to get the treatment they need, for the period of time that treatment takes. Many people need treatment in hospital and don’t get it now. This increases the belief that hospital is only if you are a

‘serious danger’ and will result in ever faster discharges. Community care is not necessarily an alternative to hospital care. Detention can keep people safe and give them a chance to recover. Detention also gives people access to s117 aftercare. This change will mean even fewer people will be able to access this. People who do not currently pose a ‘serious risk of harm’, many people with eating disorders, personality disorders, depression will no longer be seen as ill enough for a hospital admission [and] the focus of hospitals will become purely managing risk.

Learning disabilities and autism

5) We heard emphatically from several respondents that autism is not a “disorder”.

Changes in the draft Bill are welcome, we heard, but are unlikely to achieve the desired

effect in isolation without increased social care funding for specialist care. One respondent who identified as a care organisation said:

The legal framework as proposed can only work for the benefit of people with LD/autism—and others— if the right options are available for their care. Achieving these is not currently prioritised and resourced. People displaying reactive distress in inappropriate care risk being wrongly diagnosed with a specific mental disorder.

6) Additionally, several respondents noted that there is very little awareness in the NHS and police about learning disabilities and autism. Respondents also felt that more consideration urgently needs to be given to inpatient environments for people with learning disabilities and autistic people, especially children. Individuals with learning disabilities

or autism are often supported under generic adult care services, which is not appropriate. One respondent noted that people with learning disabilities and autistic people require “robust specialist placements where staff are supported and where multidisciplinary support can be accessed. However, we heard:

NHS community teams are frequently completely overwhelmed, especially in counties where there are a large number of private nursing homes catering for clients from all over the country. Frequently complex clients arrive with no background history or warning and are quickly abandoned by social workers from the county of origin for the local NHS community team to look after.

7) Many respondents expressed their concerns that people with learning disabilities or autistic people will be arrested or detained under the Mental Capacity Act's Deprivation of Liberty

Safeguards (DoLS) or the forthcoming Liberty Protection Safeguards (LPS). The LPS will still have fewer rights and safeguards than the Mental Health Act, including the ability to challenge detention, and could lead to longer stays in hospital for this group. One respondent told us that moving from the DoLS to the LPS may in fact reduce the safeguards for the rights of people lacking capacity.

8) Others were concerned that the difference between the treatment of Part III patients with learning disabilities or autism and Part II is “discriminatory” and creates a two-tier system. One respondent who identified as a care organisation told us that many people with learning disabilities and autistic people end up inappropriately in prison. They say that the proposal to differentiate access to Section 3 of the MHA between ‘civil’ patients and ‘forensic’ patients with a learning disability or autism diagnosis, is “discriminatory and harmful to the human rights of vulnerable people wrongly

channelled into the criminal justice system". The same respondent commented on the "illogicality, that autism is not a mental disorder within the meaning of the MHA, yet becomes one if an offence is committed". One respondent also told us that the problem would be exacerbated for individuals from minority groups:

Black and Asian people who are autistic and/or have learning disabilities will become more targeted by police if there isn't an alternative help for meltdowns, shutdowns or overloads.

9) We also heard that the reason people with learning disabilities or autistic people are "stuck" in hospitals is because of the lack of appropriate community provision. One respondent noted that because there are limited services for adults with autism in the country, mental health services have to step up further and are therefore under strain.

Resourcing and workforce

Expansion of services in the draft Bill

10) We heard many concerns that provisions in the draft Bill will only be possible with adequate funding, workforce investment and mandates to change and increase service provision in some areas. One respondent said: “I think the proposed changes are positive, but their cost shouldn’t be underestimated.” In particular, several respondents noted that the expansion of rights to an independent mental health advocate (IMHA) to informal patients risks causing a shortage and increasing delays. Several respondents also expressed concerns over the resourcing of Second Opinion Doctors (SOADs).

11) Some respondents wrote that legislation is not the key issue. One respondent said that the key issue is that the current system is “completely dysfunctional”. Another respondent told us:

In-patient bed provision nationally is totally inadequate and utterly overwhelmed, meaning those approved for detention under the MHA often wait days for a bed and can be placed miles from their family. Lack of inpatient beds seems to be a significant factor in deciding whether it is “appropriate” to detain someone under the MHA, and I am sceptical of the true rationale for raising the threshold for admission under section.

Community care

12) We also heard that having alternative support mechanisms and options in the community would be essential to ensure the MHA is not used as frequently. One respondent, who identified as an individual who had received mental health care as an inpatient, said:

13) Where criteria has changed for detention then other areas of care are required to be

increased. [...] Any change to mental health services requires adjustment elsewhere, as the burden will fall onto society and security forces effecting [sic] the national interest as a whole.

14) One respondent, who identified as being a care organisation, said:

We would like to see a specific focus on the role of the CQC. It needs urgently to improve its relationships with providers and its monitoring procedures, and adopt a rigorous approach to an enhanced human rights-based oversight of commissioning practice.

[...] Hospital care has been unavoidable for some, due to the risks arising from their responses to daily life. For excellent community care to replace it, commissioners, regulators and the wider multi-disciplinary team must flexibly

and proactively support and enable the required improvements and stability of services.

Data

15) Some respondents told us that there needs to be a robust mechanism for monitoring the implementation of the Bill. One respondent told us that this could be achieved by better diagnosis data. A requirement to collect and publish this data should be included in the Code of Practice, they said, as it would help identify what is driving the increases in detentions and will help to determine the interventions needed to reduce them.

Remote examinations

16) One respondent noted that remote examinations (which are often seen as a way to reduce resourcing difficulties) “risk seriously undermining the purpose of the reforms” as those with disabilities, financial inequalities,

housing inequalities are not adequately protected by the use of remote examinations. Mental health conditions are difficult to detect and need due care and attention, in person.

Patient choice

Mental health assessments

17) Some respondents felt that there was too much bureaucracy surrounding mental health assessments, commenting that “box ticking” was preventing specialists and clinicians from listening to their patients. Clinicians are not taking an individual’s own decisions and plans for treatment into account, they said. One respondent noted that teams working with mental health patients, rather than against them, will inevitably get better outcomes.

Advance choices

18) We also heard that the move towards encouraging advanced decision making is positive, and that Advance Choice Documents

(ACDs) are a vital way to record these and should be included in the Code of Practice. One respondent who identified as a mental health professional noted that it was important to review ACDs to ensure that patients understood why a decision was taken if it was for their own benefit but against their wishes in the ACD. Another respondent who also identified as a mental health professional said:

Advance statements make an appearance, but do not have the prominence they deserve. They represent an important means of ensuring that a patient's will and preferences can be clear in the future when illness does not permit the person to express these at the time. Research evidence suggests that advance statements may reduce compulsory admissions by around 25%. There should be an obligation to offer all

admitted patients, on discharge, the support to make an advance statement if they so wish.

Nominated person

19) There was general support for the Nominated Person arrangements. One respondent said, “I cannot express how much this needs to happen!”. However, we heard from several respondents that the Nominated Person arrangements need further consideration. One respondent thought that the arrangements need to be “completely rethought” as they could impede care in emergency situations and therefore exacerbate risk for the patient and others. Another echoed this concern by noting that a decision would need to be made promptly or the risks for the person are likely to increase.

20) One respondent suggested that there could be more support for the Independent Mental Health Advocate (IMHA) to help the clinician carry out this process. Another respondent

with the same concerns suggested that the opportunity to review the appointment of a Nominated Person at a later date might help. Another respondent said that this is “absolutely the right approach” but that there needs to be “a clear process to define this during an assessment and a decision making tool” similar to the process of choosing a Nearest Relative, but with more modern relationship options.

21) We also heard that choosing a Nominated Person outside of the family can put pressure on family relationships. Respondents also noted the importance of ensuring that the families and carer are still given a voice in a patient’s treatment even if they are not chosen as the Nominated Person. This is particularly important for children and young people. Additionally, one respondent who identified as a carer of someone with a mental health condition expressed their concern that not all nominated people may know the patient well enough to assist in making decisions in their best interest.

22) Another respondent noted that, for those under 18, there may be overlap between the rights of those with parental authority and those of the Nominated Person. They said that this needs to be clarified either in the law or in the Code of Practice.

Routes to discharge

Community treatment orders (CTOs)

23) One respondent told us that the idea of trying to reduce the number of CTOs by making it more difficult to make a CTO is “fundamentally flawed” as it could result in people being detained in hospital for longer.

24) Another respondent who identified as an individual who had received inpatient care for a mental health condition said that CTOs should be abolished as they have caused “untold damage to person centred, collaborative care”.

Care and Treatment reviews

25) One respondent, who identified themselves as a care organisation, said:

We appreciate the logic of mandatory C(E)TRs to ensure engagement from commissioners and prevent excessive hospital stays. The process requires listening to all the different viewpoints, including those of care providers. Accountability issues arise: front-line care providers will carry the legal responsibility for implementing recommendations, without always being properly included in reaching them.

Inequalities

26) We heard from respondents that the draft Bill does not go far enough to address “systemic racism”. This needs to be addressed at a more macro level, we heard, as minority communities are more impacted by poverty

and unemployment, which may impact mental health. We also heard concerns from one respondent that the Bill was still “too subjective” as one person’s perception of risk is different from another’s. Another respondent said that tackling this issue requires mandatory awareness training and culture change in the workforce.

27) Culturally appropriate advocacy was seen as vital to improving racial inequalities in the use of the Mental Health Act. One respondent wrote that the fact that it had been left out of the draft Bill is “disastrous” and that they fear this “vital role” will be “bolted on to the current IMHA services across the country” and fail to deliver the results the Wessely Review wanted. Another respondent said that patients from black and minority ethnic communities need advocates from their own background so that they can trust that they will be listened to properly and understood.

Children and young people

28) One respondent told us that there is a “startling and worrying” lack of mental health service provision for children and young people. They said that this is pushing children and young people into crisis and exacerbating conditions which could be well managed with early intervention:

More and more it seems CAMHS rely on parents taking a private route for diagnosis and treatment, which is wrong, and often unaffordable. CAMHS have capacity to deal only with the most serious cases of [children and young people] in [mental health] crisis, whilst waiting for those on waiting lists to get to that critical point before offering support which is by then too late, and creates a conveyor belt of unending demand. This demand will then inevitably continue into

adult services, resulting in a lifetime of reliance on [mental health] support and NHS resources.

Tribunals

29) One respondent said that Tribunals need more powers, especially reviewing appropriateness and progress of treatment plans for individuals.

30) Several respondents also stated that Tribunals will need more resources to avoid undue delay in hearings. One respondent said that the current Tribunal system is “broken” and that increasing the number and frequency of Tribunals will result in “cursory Tribunals with poorly prepared reports and ineffective representation”. One respondent who identified as a mental health professional said:

staff are already struggling to meet the requirements to prepare reports and attend Tribunals and that resources

must be increased if access to Tribunals is increased, otherwise there may be an increase in premature discharges to avoid the necessity of undertaking this work.

31) We also heard that Tribunals can be very stressful for patients, and that greater care needs to be taken to help these individuals manage the process. One respondent suggested that automatic referrals to a Tribunals should also apply to people subject to a Conditional Discharge from Section 37, where conditions restrict the person's freedoms.

Crisis management

32) One respondent told us that crisis provision of places of safety is “woefully inadequate nationally”, often resulting in patients in crisis waiting with police officers or in police vehicles for over twelve hours.

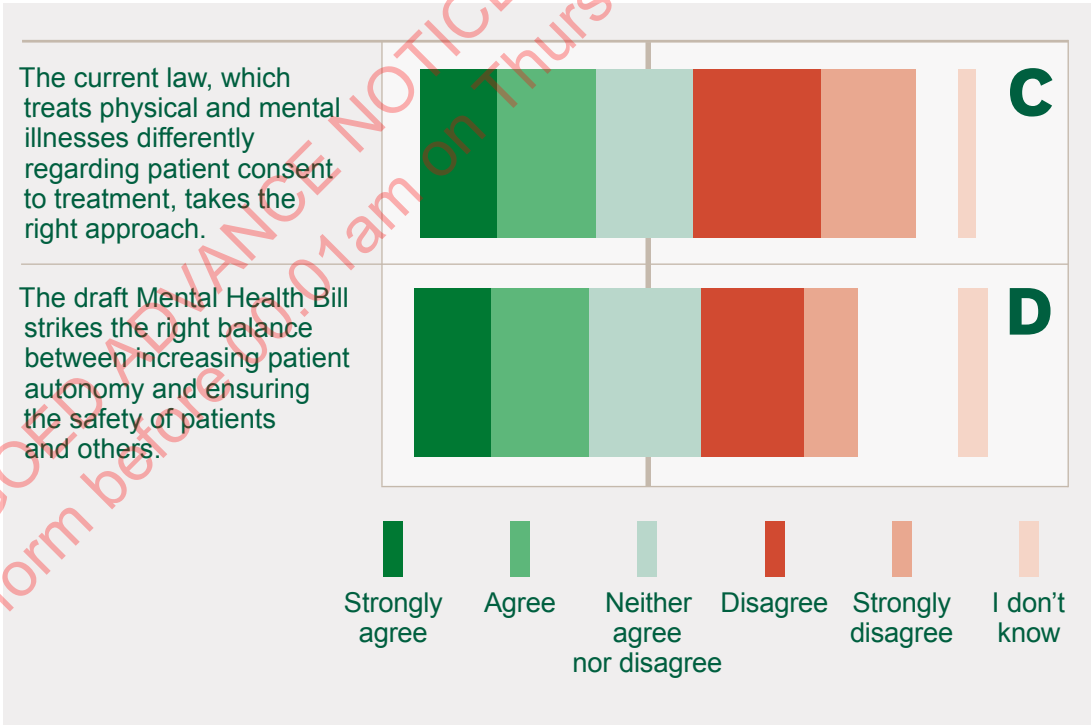
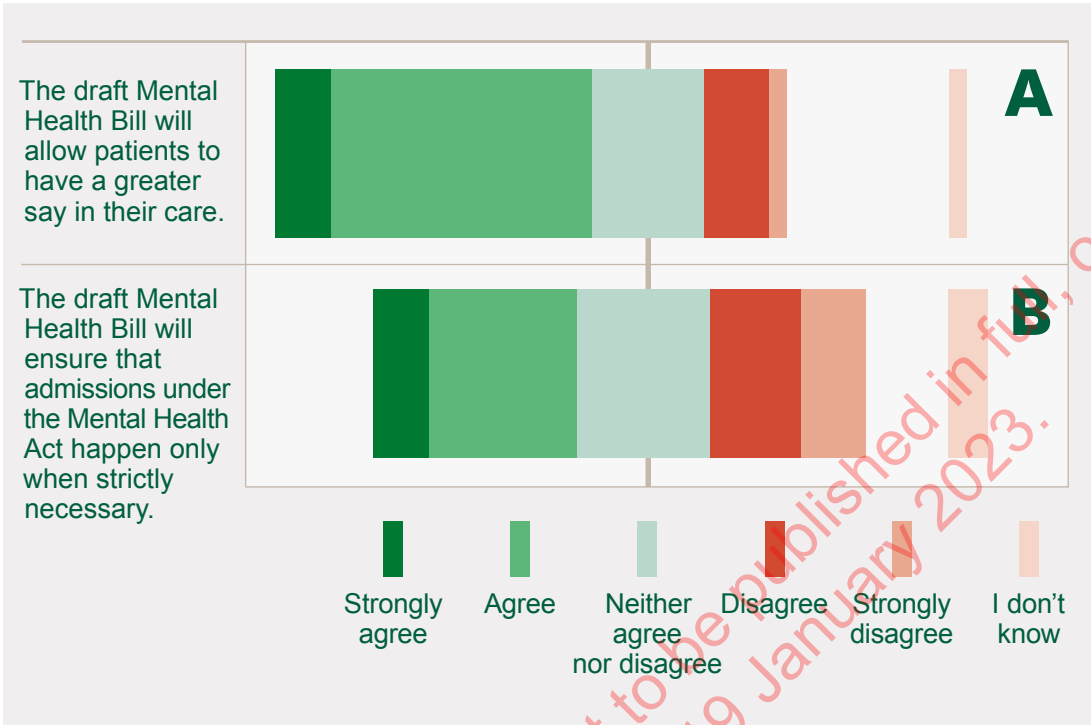
33) We have heard from several respondents that there are problems providing less restrictive alternatives in the community to people who have a short-term crisis. There are no alternatives to hospital to keep them safe for a short time. One respondent told us that there need to be more available places of safety:

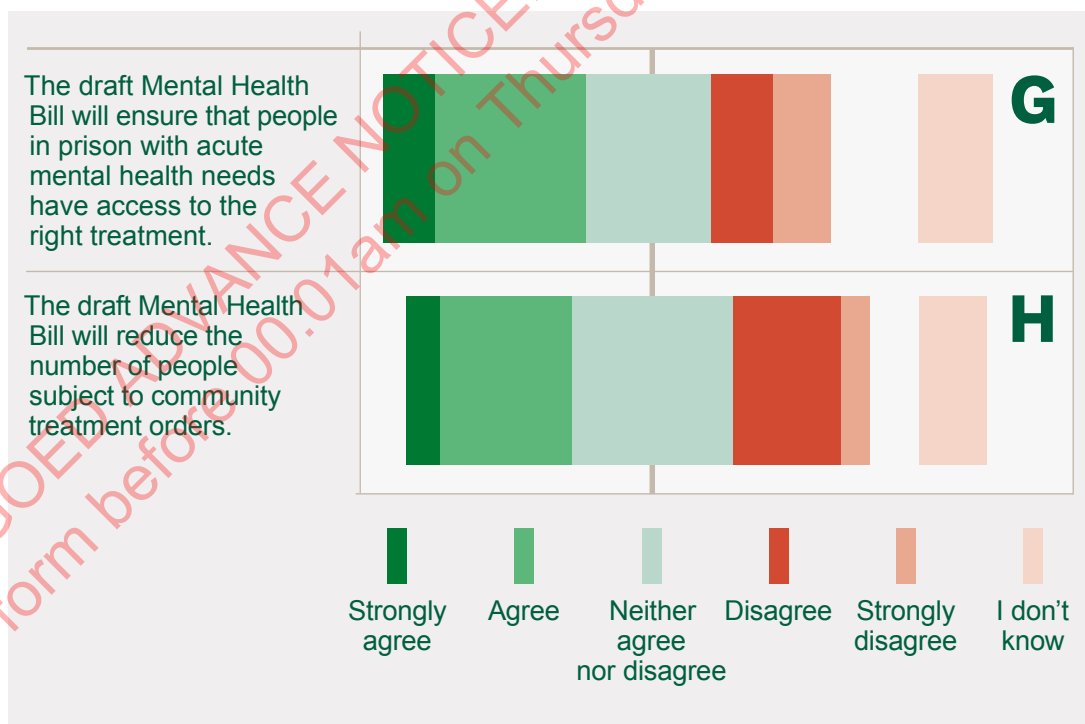
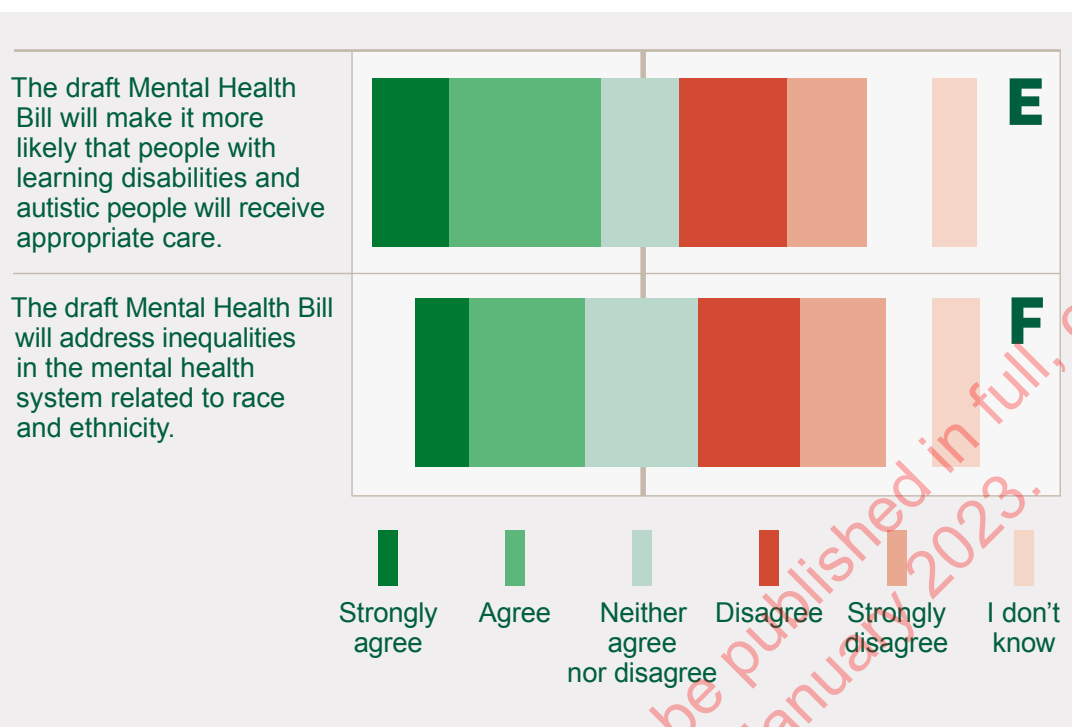
Prison and cells are not appropriate as places of safety, but there needs to be an increase in appropriate places. Simply filling up A&E with patients handcuffed to stretchers is also inappropriate, and makes it harder for those who are seeking help from A&E. A similar problem occurs because of a lack of appropriate places for children in a mental health crisis, who end up waiting on [a] children's medical ward, requiring large amounts of resources as their distress is not being addressed, and impacting on the care of others.

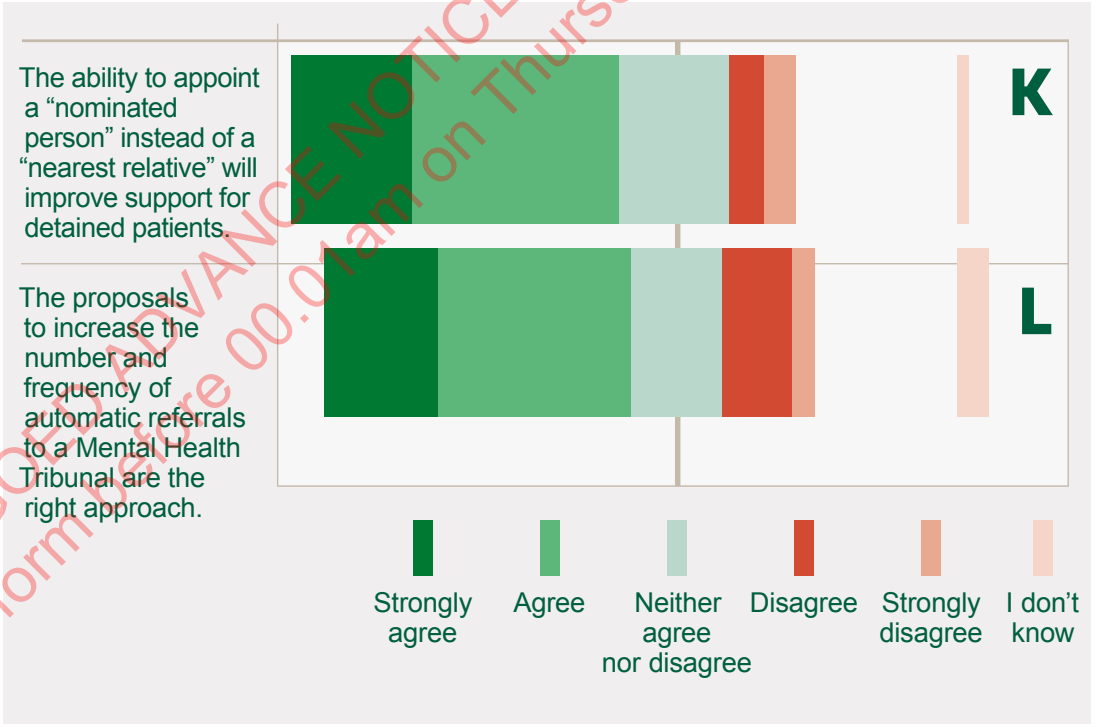
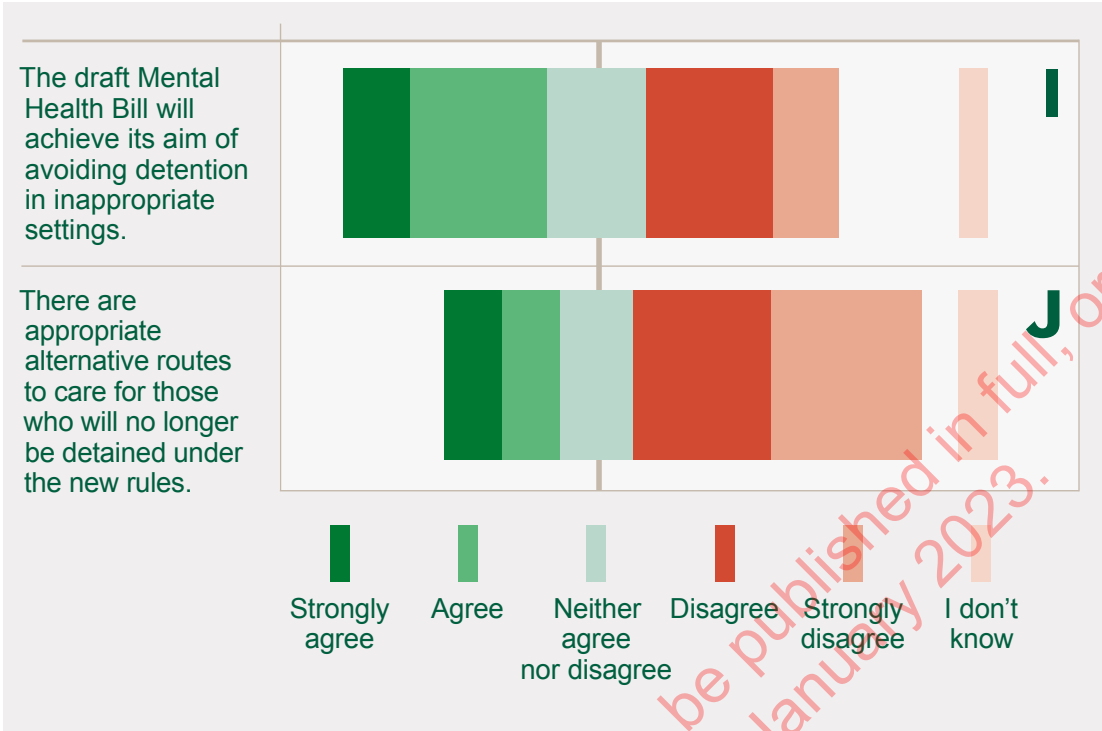
34) We have also heard that arguably a legal gap exists in the division between the proposed use of the Mental Health Act and the Mental Capacity Act's Liberty Protection Safeguards. This becomes especially evident in crisis situations. One respondent told us:

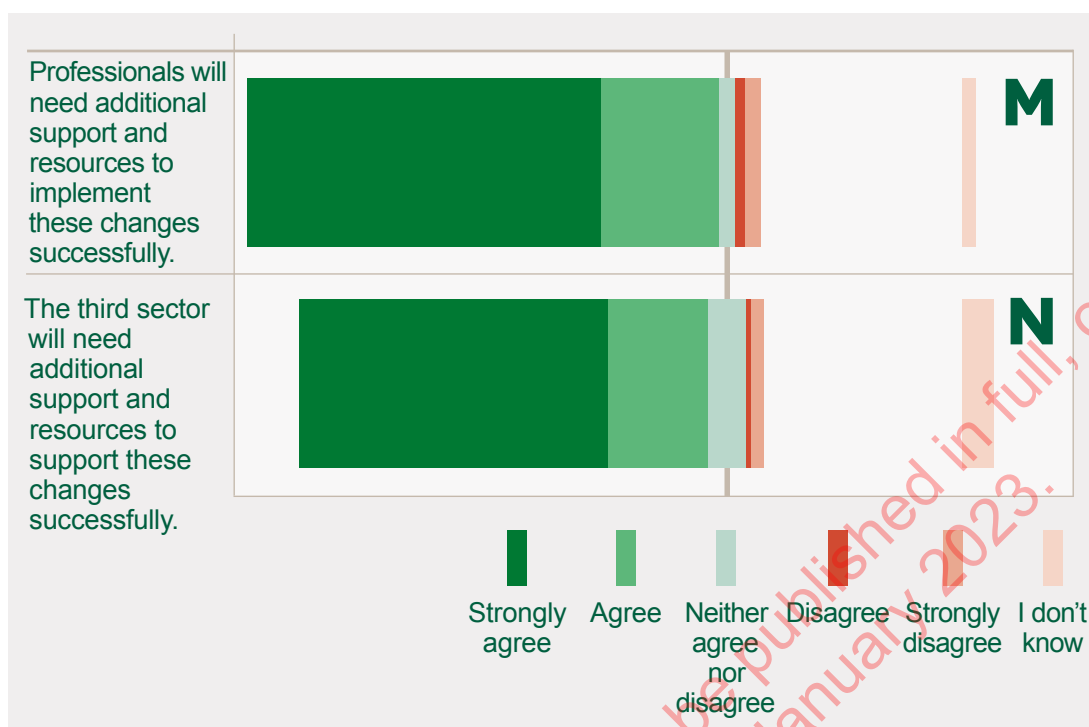
The MCA makes no provision for people deprived of their liberty who lack capacity, but who present a risk to others rather than to themselves; this makes [the] LPS potentially unavailable to protect their rights. A foreseeable consequence of finding both schemes unavailable is inappropriate recourse to criminal justice.

Question responses









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Appendix 2: Service User Roundtable

1) We held a private roundtable with people who have been or are currently under the Mental Health Act in October 2022. The discussions in the roundtable are summarised here.

Experiences under the Mental Health Act

2) One of the key messages we received from service users was that they felt a loss of rights is intrinsic in the Act, leaving people feeling powerless. Under detention they felt like they had lost their voice entirely. One service user described being moved from hospital to hospital five times, sometimes at no notice.

3) We also heard that there is still a great deal of stigma inherent in the Act, despite mental health issues affecting a large part of the population. We heard that services were unavailable to people outside of the Mental Health Act, meaning that some service users were encouraged towards detention so that

they could access treatment. They said that it was not right that people should have to go to hospital for care and housing. When under the Act, it became a “holding pen” while they waited for appropriate community treatment. On discharge, there is then a lack of resource to prevent readmission.

4) Some service users felt that it was still important to have admission to hospital as an option, even if there was excellent community care. The main issue of hospital admissions is that when in hospital, service users stay longer than they need to, particularly those with learning disabilities and autism. One service user with a learning disability who had been in hospital care for over twenty-five years said that they were never given a chance to live in the community. We heard that with better community care, living in the community would become a more viable option and that fewer

people would be admitted in crisis. They told us that if they had received help when they asked for it, they would not have ended up in hospital.

Learning disabilities and autism

5) Service users with learning disabilities or autism told us that they did not feel listened to or understood by staff and carers. In places where teams had been specially trained in autism and had support packages available, however, we heard that this experience did improve. We also heard from other service users that the symptoms of psychosis were little understood, despite being a prevalent condition. Another user told us that even on a specialist autism unit, their needs were ignored, with staff treating them for a co-occurring personality disorder.

6) We heard that service users with learning disabilities and autism wanted more treatment options available than medication and detention. For example, talking therapies and cognitive behavioural therapy. We heard a positive review

of the Improving Access to Psychological Therapies programme (IAPT), but that time limits were too short for the user to experience therapeutic benefit. They thought that personally adapted therapy would be more beneficial, and that peer support should be more encouraged. One user had a Personal Health Budget which they considered highly beneficial as it allowed them to recruit their own staff. We also heard that co-production of care and treatment with service users can be beneficial.

Care and treatment provision

7) Service users told the Committee that recommendations in Care and treatment plans were rarely actioned, and that the process can become a box-ticking exercise. They found this very frustrating and recommended that Care and treatment plans should contain hard and fast obligations to carry out the recommendations. These recommendations should be distributed to all those involved with

the patient's care. It would also be beneficial for users to have more involvement in their Care and treatment plan.

Patient passports

8) One service user mentioned their positive experience with a 'patient passport', which contained information about their previous admissions to inpatient services, notes about situations that are triggering, and information about medication that has or hasn't worked. The user told us that this document had been useful when they were previously in crisis and had been detained in a police cell. The police were able to check with a local hospital to see whether they were known, which resulted in the user being cared for appropriately. The document now gives them confidence that, should they be detained again, they have this information to fall back on.

Patient safety

9) We also heard that little thought is given to patient safety in inpatient settings. Service users told us about difficult and traumatic experiences from being placed in mixed wards. We heard that the experience of women in mental health services, and the additional dangers they face, had not been considered in the draft Bill. Additionally, 'halfway houses' offered to service users upon discharge were often not safe places. One service user told us that she had come out of inpatient services with more trauma than when she went in because of these issues.

Discharge planning

10) Service users told us that discharge plans should be developed as soon as possible after detention. This should have a clear time frame with a clear plan of what treatment was planned, with the aim of discharging the patient as soon as possible.

11) Service users we heard from felt that Community Treatment Orders (CTOs) were an easier way for clinicians to manage discharge, but that this was just a way to pass on responsibility. One service user told us that they knew someone who felt so restricted under a CTO that they tried to take their own life.

12) We also heard concerns that private providers have little incentive to discharge patients and often do not provide adequate support. It was recommended that services be taken out of private hands and better regulated.

Proposals in the draft Bill

13) Some service users told us that the proposals in the draft Bill appeared likely to make clinicians listen to patients' voices and concerns. Other service users noted that the draft Bill is still based on a model of risk reduction, with too much riding on a user's capacity to make decisions. Some felt that it would be important to consider a rights-

based approach and follow the United Nations Convention on the Rights of Persons with Disabilities.

14) Advance choices were seen by service users as key. Service users were also very positive about the change from 'nearest relative' provisions to 'nominated person'. Some service users also told us that good community support also meant having activities as well as medical care, as they can feel isolated.

Advocacy

15) Service users felt that the focus on advocacy was important and welcome. However, one service user who works closely with advocacy services and expressed his concern that the services do not have the capacity to meet the increased demand resulting from the draft Bill's proposal to make advocacy services statutory.

Racial inequalities

16) Other service users expressed their concerns that changes in the draft Bill did not go far enough to address inequalities in the use of the Act, including the disproportionate representation of racial minority groups in inpatient settings. Service users from minority backgrounds told us that their clinicians did not understand their cultural or religious needs, making it challenging to find appropriate care. The lack of consideration for racial minority groups can make service users from these backgrounds feel unseen, for example, a lack of the appropriate combs or hair dressing expertise can leave some service users unable to manage their hair and appearance appropriately.

Resources

17) Many service users were concerned by the lack of resources for mental health inpatient and community services. We heard that community services are the best place to manage mental

health as no one wants to be in hospital, and care feels so much better when it is delivered in a familiar local environment with minimal upheaval. However, these community services need to be properly resourced.

18) Some service users were concerned about the loss of Section 117 aftercare for people with learning disabilities and autistic people as this has the potential to make it even harder to access community services upon discharge.

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Appendix 3: Drafting Points

Clause	Text	Committee's comments
4(3)	<p>In section 20A (community treatment period)—...</p> <p>(c) for subsection (7) substitute—</p> <p>“(7) Subsection (6) of section 17A applies for the purposes of subsection (4) (b) of this section as it applies for the purposes of subsection (4)(a) of that section.”</p>	<p>Clause 4(3) makes changes to section 20A of the Act that require the reader to cross-reference section 17A, which means going backwards and forwards between the two sections. The change made by clause 4(3)(c) in particular is difficult to apply because it requires the reader to envisage a provision of section</p>

Clause	Text	Committee's comments
	<p>17A applying for the purposes of section 20A.</p> <p>It would be preferable to make the amended section easier to understand, for example by adopting the wording of section 17A(6) and putting it directly into section 20A.</p> <p>(See similar comments on clauses 26(5) and 39(3).)</p>	

Clause	Text	Committee's comments
6(2)	...(i) has a reasonable prospect of alleviating, or preventing the worsening of, the disorder or one or more of its symptoms or manifestations ...	The definition of “appropriate medical treatment” in the new section 1A includes the condition that treatment has a reasonable prospect of alleviating, or preventing the worsening of, “manifestations” of the disorder concerned. This definition is potentially wide. It appears to cover self-harm and harm to others. So it may

Clause	Text	Committee's comments
		<p>go beyond what might otherwise be considered “therapeutic benefit”, which appears to be the intention of the provision. If it is intended to be narrower in scope (to avoid detaining people on the basis only of propensity to commit harm), it would be preferable for the drafting to be amended to make this clearer.</p>

Clause	Text	Committee's comments
8(5)	For section 64 (supplementary provisions for Part 4), for subsection (1) substitute...	It appears that this should read “ In section 64...” (the provision is substituting the subsection, not the whole section). (As with the other sub-clauses.)

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Clause	Text	Committee's comments
11(2)	This section applies to the forms of medical treatment for relevant disorder mentioned in subsection (2)...	<p>It isn't immediately clear from the wording "relevant disorder" – without a preceding word that might be expected grammatically, such as "a", "the", or "any" – whether only one such disorder is being referred to, or potentially more than one disorder that any patient might have.</p> <p>It is understood that in fact more than one disorder</p>

Clause	Text	Committee's comments
		<p>is intended to be captured. In which case, it would be preferable for all references to “relevant disorder” be amended to read “any relevant disorder” (except where only one such disorder is intended), so this is made clear to the reader.</p>

Clause	Text	Committee's comments
11(8)(a)	...(ii) the administration of medicine to the patient by any means (not being a form of treatment specified under section 57, section 58(1)(a) or section 58A(1)(b)) if a period equal to or longer than the section 58 period has elapsed since the first occasion, during the relevant period, when	It is assumed that “the administration of medicine” at the start of this provision refers to the same medicine as “when medicine was administered” at the end. Read literally, different medicines could be being referred to. To resolve any ambiguity, it would be preferable to qualify the second reference to “medicine” (for

Clause	Text	Committee's comments
	medicine was administered to the patient by any means for relevant disorder...	example “that medicine”).

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Clause	Text	Committee's comments
22(2) New section 11(4C)	Where a nominated person objects under subsection (4B) to the making of an application, the application may be made only if it is accompanied by a report certifying that, in the opinion of the approved mental health professional, the patient, if not admitted for treatment or received into guardianship,	<p>The word “likely” here is ambiguous. Does it mean more probable than not (i.e. more than a 50% chance), or a reasonable chance or real possibility (i.e. not necessarily more than a 50% chance)?</p> <p>It is understood that the intention is to follow the Code of Practice, which in turn takes into account the approach in the</p>

Clause	Text	Committee's comments
	would be likely to act in a manner that is dangerous to other persons or to the patient.”	<p>case of <i>Re JR [2011] NIQB 17</i>. However, it is still not obvious what the relevant meaning would be (the Code refers only to “probability” in general terms, rather than the level of probability, and the case refers to a test of “real probability”, which is itself potentially confusing).</p> <p>It would be clearer for the legislation itself to set out</p>

Clause	Text	Committee's comments
		precisely what the test is: i.e. is it more probable than not, or something else?

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Clause	Text	Committee's comments
22(3)	<p>...in subsection (5)—</p> <p>(i) the words from “one” to the end become paragraph (a), and</p> <p>(ii) after that paragraph insert—</p> <p>“(b) if the patient appears to have a nominated person, the nominated person”...</p>	<p>The effect of this amendment would be that the responsible clinician must consult “(a) one or more other persons who have been professionally concerned with the patient’s medical treatment,</p> <p>(b) if the patient appears to have a nominated person, the nominated person.” There is no conjunction between (a) and (b).</p>

Clause	Text	Committee's comments
		It is assumed that both persons in a) and b) need to be consulted, rather than either one or the other. But it would be preferable to confirm (for example, by adding “and” between them).

Clause	Text	Committee's comments
26(5), inserting new para. 2ZA to Sch.1	<p>“2ZA (1) Section 20 is to apply with the modifications specified in paragraph 5B if—</p> <p>(a)...</p> <p>(b)...</p> <p>(2) Otherwise, section 20 is to apply with the modifications set out in paragraph 6.”</p>	<p>The provision inserted into Schedule 1 requires the reader to go backwards and forwards between the Schedule and section 20, trying to mentally hold information from the one to apply it to the other.</p> <p>The drafting approach here appears to follow that elsewhere in Schedule 1, but it would be easier</p>

Clause	Text	Committee's comments
		<p>for the reader if a modified version of section 20 could be set out in full.</p> <p>(See similar comments on clauses 4(3) and 39(3).)</p>

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Clause	Text	Committee's comments
39(3)	<p>“(3A) In applying subsection (3) for the purpose of determining the local social services authority in relation to a person—</p> <p>(a) section 105(6) of the Children Act 1989...</p> <p>(b) the following provisions apply for the purpose of determining the person's ordinary residence at any</p>	<p>The insertion of section 117(3A) achieves its effects by applying modified provisions of other legislation. This requires the reader having to go back and forth between different pieces of legislation, and mentally reconstructing provisions that apply in this mental health context.</p> <p>It would be easier for the reader if the</p>

Clause	Text	Committee's comments
	time when they were aged 18 or over..."	<p>modified provisions themselves could be set out in one place.</p> <p>(See similar comments on clauses 4(3) and 26(5).)</p>

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Formal minutes

Wednesday 11 January 2023

Members present

Baroness Buscombe, in the Chair

Baroness Barker

Baroness Berridge

Lord Bradley

Baroness Hollins

Baroness McIntosh of Hudnall

Dr Rosena Allin-Kahn

Marsha de Cordova

Dr Dan Poulter

Dr Ben Spencer

Sir Charles Walker

Declarations of Interests

Baroness Hollins declared an interest as a member of the Building the Right Support

Delivery Board in her role as Chair of the Independent Care (Education) Treatment Reviews Oversight Panel.

Dr Dan Poulter drew attention to his previously declared interest as an NHS psychiatrist employed by an NHS Trust.

Draft Mental Health Bill

Draft Report (*Draft Mental Health Bill 2022*), proposed by the Chair, brought up and read.

Ordered, That the Chair's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 366 read and agreed to.

Appendix 1 read and agreed to.

Appendix 2 read and agreed to.

Appendix 3 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Report of the Committee to both Houses.

Ordered, That the Chair make the Report to the House of Lords and that Sir Charles Walker make the report to the House of Commons.

Ordered, That embargoed copies of the report be made available, in accordance with the provisions of House of Commons Standing Order No.134.

The Committee adjourned.

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Declaration of interests

Lords' Members Declared Interests

Baroness Buscombe

(Conservative, Life Peer)

Category 4: Shareholdings (b)

- Antofagasta plc (metals and mining)
(interest ceased 12 April 2022)

Category 8: Gifts, benefits and hospitality

- From time to time the member receives hospitality from the All-Party Parliamentary Group for the Armed Forces, the All-Party Parliamentary Group for Shooting and Conservation, the All-Party Parliamentary Group on France, the All-Party Parliamentary Group for the Polar Regions, the All-Party Parliamentary Gardening and Horticulture Group, the Inter-Parliamentary Union and the British Group Inter-

Parliamentary Union which over the course of a calendar year may exceed £300 in value

Category 10: Non-financial interests (b)

- Other Working Benchers, Inner Temple (as part of this role, the member has also been appointed to the Estates Committee of the Inner Temple)

Category 10: Non-financial interests (e)

- Trustee, Goring Gap Environmental Organisation

Baroness Barker

(Liberal Democrat, Life Peer)

Category 2: Remunerated employment, office, profession etc.

- Self-employed Management Consultant, trading name: Third Sector Business

(income received from the member's work in this connection is paid to Third Sector Business)

Category 10: Non-financial interests (e)

- President, National Association of Care Catering
- Board Member, UK-Japan 21st Century Group
- Trustee, GiveOut (charity)
- Ambassador, Albert Kennedy Trust
- Vice President, Peter Tatchell Foundation
- Member of Rethink's advisory group

Baroness Berridge

(Conservative, Life Peer)

Category 2: Remunerated employment, office, profession etc.

- Barrister (non-practising)

- Parliamentary Under Secretary of State for the School System, Department for Education and Parliamentary Under Secretary of State (Minister for Women), Department for International Trade (interest ceased 17 September 2021)

Category 3: Person with significant control of a company (PSC)

- Freedom Declared Foundation

Category 6: Sponsorship

- The member receives up to £10,000 a year from a number of friends and family to enable her to meet the cost of secretarial and research support in connection with her duties in the House of Lords

Category 10: Non-financial interests (a)

- Director (formerly Chairman of Trustees), Freedom Declared Foundation (charity and private limited company by guarantee

without share capital; use of 'Limited' exemption; research on social sciences/humanities)

Lord Bradley

(Labour, Life Peer)

Category 2: Remunerated employment, office, profession etc.

- Non-executive Chair, Manchester, Salford and Trafford NHS LIFT Company
- Non-executive Chair, Bury Tameside and Glossop NHS LIFT Company

Category 6: Sponsorship

- Some secretarial support is provided by University of Manchester
- Some secretarial support is provided by University of Salford

Category 10: Non-financial interests (a)

- Member, Advisory Board for Female Offenders (Ministry of Justice) (interest ceased 15 March 2022)

Category 10: Non-financial interests (b)

- Chair of Council, University of Salford
- Honorary Special Adviser, University of Manchester
- Honorary Fellow, Royal College of Speech and Language Therapists
- Chair, Non-custodial Partnership Advisory Group (NHS)
- Chair, Independent Advisory Group - Self Harm in the Women's Prison Estate (HMPPS) (interest ceased 7 November 2022)

Category 10: Non-financial interests (e)

- Trustee, Centre for Mental Health
- Trustee, Prison Reform Trust

Baroness Hollins

(Crossbench, Life Peer)

Category 2: Remunerated employment, office, profession etc.

- Miscellaneous fees and honoraria from lecturing and writing
- Chair, Independent Oversight Panel to review the use of seclusion and segregation for adults with learning disabilities/autism

Category 3: Person with significant control of a company (PSC)

- Lets Belong Ltd

Category 4: Shareholdings (a)

- Lets Belong Ltd (non-residential care and support for disabled adults) (interest ceased 1 January 2022)

Category 6: Sponsorship

- One day per week during term time, the member has the benefit of expertise from

a mental health practitioner attached
to the Royal College of Psychiatrists
Parliamentary Scholar Programme

Category 9: Miscellaneous financial interests

- Appointee for member's disabled son's welfare benefits

Category 10: Non-financial interests (a)

- Chair, Books Beyond Words CIO (grants and contracts are received from various government and non-government sources)
- Director, Lets Belong Ltd (non-residential care and support for disabled adults)

Category 10: Non-financial interests (b)

- Emeritus Professor of Psychiatry of Disability, St George's, University of London

- Honorary Professor of Spirituality, Theology and Health, Department of Theology and Religion, University of Durham
- President, Royal College of Occupational Therapists
- Chair of Scientific Advisory Board, Centre for Child Protection, Pontifical Gregorian University, Rome (interest ceased 31 August 2021 - notified 8 November 2021)
- Honorary Professor of Intellectual Disability, Faculty of Health, Social Care & Education, Kingston and St George's (joint enterprise of Kingston University and St George's, University of London)

Category 10: Non-financial interests (e)

- Vice President, Institute of Psychotherapy and Disability
- President, Royal Medical Benevolent Fund
- Patron, Living and Dying Well

Other declared interests

- Family carer of a person with learning disabilities/autism
- Independent consultant to the Department of Health and Social Care around people with learning disability and autistic people are detained in long-term segregation.

Baroness McIntosh of Hudnall

(Labour, Life Peer)

Category 2: Remunerated employment, office, profession etc.

- Occasional freelance work for Clore Leadership Programme

Category 3: Person with significant control of a company (PSC)

- RSCA Limited (interest ceased 11 November 2021)
- RSC Enterprise Limited (interest ceased 11 November 2021)

- RSC Estates Limited (interest ceased 11 November 2021)
- RSC Productions Limited (interest ceased 11 November 2021)
- RSC Matilda US Limited (interest ceased 11 November 2021)
- RSC Pre-productions Limited (interest ceased 11 November 2021)
- RSC Matilda Australasia Limited (interest ceased 11 November 2021)
- RSC Touring Limited (interest ceased 11 November 2021)

Category 10: Non-financial interests (b)

- Member, Middlesex Learning Trust
(oversees operation of three academy schools in North London)

Category 10: Non-financial interests (c)

- Deputy Chairman and Board Member, Royal Shakespeare Company (interest ceased 11 November 2021)

Category 10: Non-financial interests (e)

- Trustee, Artis Foundation

Commons' Members Declared Interests

Allin-Khan, Dr Rosena (Tooting)

1. Employment and earnings

- Payments received from St George's Hospital NHS Trust, Blackshaw Road, London SW17 0QT, for my work as a doctor:
- 30 June 2021, received £622. Hours: 10 hrs. (Registered 30 June 2021)
- 21 July 2021, received £570 for a shift worked on 9 July 2021. Hours worked: 10 hrs. (Registered 17 August 2021)

- 21 July 2021, received £665 for shift worked on 11 July 2021. Hours: 10 hrs. (Registered 17 August 2021)
- 28 July 2021, received £585. Hours: 10.25 hrs. (Registered 17 August 2021)
- 4 August 2021, received £585. Hours: 10.25 hrs. (Registered 17 August 2021)
- 11 August 2021, received £600 for a shift worked on 27 July 2021. Hours: 10 hrs. (Registered 17 August 2021)
- 11 August 2021, received £435 for a shift worked on 30 July 2021. Hours: 8 hrs. (Registered 17 August 2021)
- 28 October 2021, received £525 for a shift worked on 13 October 2021. Hours: 8 hrs. (Registered 25 November 2021)
- 3 November 2021, received £665 for a shift worked on 23 October 2021. Hours: 10 hrs. (Registered 25 November 2021)

- 10 November 2021, received £665 for a shift worked on 31 October 2021. Hours: 10 hrs. (Registered 25 November 2021)
- 29 December 2021, received £480 for a shift worked on 12 December 2021. Hours: 8.5 hrs. (Registered 24 January 2022)
- 12 January 2022, received £665. Hours: 10 hrs. (Registered 07 February 2022)
- 12 January 2022, received £450. Hours: 8 hrs. (Registered 07 February 2022)
- 19 January 2022, received £665. Hours: 10 hrs. (Registered 07 February 2022)
- 19 January 2022, received £595. Hours: 9 hrs. (Registered 07 February 2022)
- 10 March 2022, received £525. Hours: 8 hrs. (Registered 31 March 2022)
- 27 April 2022, received £570. Hours: 10 hrs. (Registered 27 April 2022)

- Payments from the GP Surgery, 6–10 St George's Road, Wimbledon SW19 4DP, for assisting with holiday cover for GPs on annual leave: 6 May 2021, received £572. Hours: 10 hrs. (Registered 03 June 2021)
- 15 November 2021, payment of £120 from YouGov, 50 Featherstone Street, London EC1Y 8RT, for a survey. Hours: 1 hr. (Registered 14 December 2021)

2. (b) Any other support not included in Category 2(a)

Name of donor: Trust Reservations Ltd

Address of donor: Merchant House, 5 East St.
Helen Street, Abingdon OX14 5E

Amount of donation or nature and value if
donation in kind: £5,000 Date received: 6
October 2021

Date accepted: 6 October 2021

Donor status: company, registration 03829637
(Registered 26 October 2021)

Name of donor: Caroline Hirons Ltd

Address of donor: 1 Mountview Court, 310
Friern Barnet Lane, London N20 0LD

Amount of donation or nature and value if
donation in kind: £10,000 to fund a political
adviser in my office

Date received: 16 December 2021

Date accepted: 16 December 2021

Donor status: company, registration 09131128

(Registered 13 January 2022; updated 28 March
2022

Name of donor: David Kogan Ltd

Address of donor: Beacon House, 113
Kingsway, London WC2B 6PP

Amount of donation or nature and value if
donation in kind: £7,500

Date received: 31 January 2022

Date accepted: 14 February 2022

Donor status: company, registration 11870524

(Registered 25 February 2022)

Name of donor: Chris Killourhy

Address of donor: private

Amount of donation or nature and value if
donation in kind: £5,000 to fund a political
adviser in my office

Date received: 22 February 2022

Date accepted: 28 February 2022

Donor status: individual

(Registered 28 February 2022; updated 28
March 2022)

Name of donor: Henley Homes

Address of donor: 50 Havelock Terrace, London
SW8 4AL

Amount of donation or nature and value if
donation in kind: £2,000 to fund a political
adviser in my office

Date received: 1 March 2022

Date accepted: 25 March 2022

Donor status: company, registration 3718331

(Registered 20 April 2022)

Name of donor: DCD London

Address of donor: 85 Strand, London WC2R
0DW

Amount of donation or nature and value if
donation in kind: £5,000 to fund a political
adviser in my office

Date received: 3 March 2022

Date accepted: 25 March 2022

Donor status: company, registration
02896868(Registered 20 April 2022)

Name of donor: Henley Homes

Address of donor: 50 Havelock Terrace, London
SW8 4ALAmount of donation or nature and

value if donation in kind: £2,000 to fund a political adviser in my office
Date received: 28 April 2022

Date accepted: 4 May 2022

Donor status: company, registration 3718331
(Registered 19 May 2022)

4. Visits outside the UK

Name of donor: David Kogan Ltd

Address of donor: Beacon House, 113 Kingsway, London WC2B 6PP

Estimate of the probable value (or amount of any donation): £1,200 accepted on 25 March 2022 as reimbursement for the costs of flights, accommodation, transportation and luggage fees

Destination of visit: Lviv, Ukraine

Dates of visit: 10–13 March 2022

Purpose of visit: To provide humanitarian assistance in my capacity as a doctor, and also

medical training to 250 doctors in Ukraine with the non-profit organisation, MedGlobal.

(Registered 20 April 2022)

De Cordova, Marsha (Battersea)

1. Employment and earnings

12 February 2021, received £200 from Leigh Day (solicitors), Priory House, 25 St John's Ln, London EC1M 4LB, for speaking at an event.

Hours: 1 hr. (Registered 10 June 2021)

2. (b) Any other support not included in Category 2(a)

Name of donor: Henley Homes

Address of donor: 50 Havelock Terrace, London SW8 4AL

Amount of donation or nature and value if donation in kind: 30 laptops for distribution to schools across my constituency, value £6,000

Date received: 22 February 2021

Date accepted: 22 February 2021

Donor status: company, registration 05764628

(Registered 09 June 2021)

Gullis, Jonathan (Stoke-on-Trent North)

**2. (b) Any other support not included in
Category 2(a)**

Name of donor: Longrow Capital Ltd

Address of donor: Livery Place, 35 Livery St,
Birmingham B3 2PB

Amount of donation or nature and value if
donation in kind: £2,000

Date received: 2 July 2021

Date accepted: 2 July 2021

Donor status: company, registration 10922505

(Registered 05 July 2021)

Name of donor: Domenico Meliti

Address of donor: private

Amount of donation or nature and value if
donation in kind: £1,600

Date received: 15 November 2021

Date accepted: 15 November 2021

Donor status: individual

(Registered 17 November 2021)

Name of donor: Quinn Estates Ltd

Address of donor: The Cow Shed, Highland
Court Farm Bridge nr Canterbury CT4 5HW

Amount of donation or nature and value if
donation in kind: The services of a public affairs
company, 5654 & Company, between 7 March
2022 and 4 April 2022 for a national campaign
on grammar schools, value £7,200

Date received: 7 March 2022 - 4 April 2022

Date accepted: 7 March 2022

Donor status: company, registration 05150902

(Registered 28 March 2022)

Name of donor: James Starkie

Address of donor: private

Amount of donation or nature and value if
donation in kind: £2,000

Date received: 12 April 2022

Date accepted: 12 April 2022

Donor status: individual

(Registered 27 April 2022)

3. Gifts, benefits and hospitality from UK sources

Name of donor: Bet365 Group Ltd

Address of donor: Bet 365 House, Media Way,
Stoke-on-Trent ST1 5SZ

Amount of donation or nature and value if
donation in kind: Four hospitality matchday
tickets to Stoke City FC vs Fulham FC, value
£540

Date received: 22 January 2022

Date accepted: 22 January 2022

Donor status: company, registration 04241161

(Registered 28 February 2022)

Name of donor: Port Vale Football Club Ltd

Address of donor: Vale Park, Hamil Road,
Stoke-on-Trent ST6 1AW

Amount of donation or nature and value if
donation in kind: Two match day hospitality
tickets for the League Two Play Off Final at
Wembley Stadium, value £1,000

Date received: 28 May 2022

Date accepted: 28 May 2022

Donor status: company, registration 08876768

(Registered 06 June 2022)

Name of donor: Port Vale Football Club Ltd

Address of donor: Vale Park, Hamil Road,
Stoke-on-Trent ST6 1AW

Amount of donation or nature and value if
donation in kind: Two hospitality tickets for
Robbie Williams Homecoming concert at Vale
Park, value £400

Date received: 4 June 2022

Date accepted: 4 June 2022

Donor status: company, registration 08876768

(Registered 13 June 2022)

Poulter, Dr Dan (Central Suffolk and North Ipswich)

1. Employment and earnings

From 1 April 2022 until further notice, I am employed on a flexible contract as a NHS psychiatrist by a London NHS Foundation Trust together with the London Deanery, Stewart House, 32 Russell Square, London WC1B 5DN. I receive an annual salary of £45,995. First payment received on 22 April 2022.

Hours: approx. 720 hrs per year. (Registered 01 December 2015; updated 07 June 2016, 07 December 2016, 29 August 2017, 27 March 2018, 01 August 2018, 07 December 2018, 02

June 2020, 27 April 2021, 04 May 2021, 02 August 2021, 24 February 2022 and 25 April 2022)

From 19 July 2021 until further notice, Non-executive Director of Kanabo Group PLC (pharmaceuticals and telemedicine), Churchill House, 137–139 Brent Street, London NW4 4DJ. I receive £24,000 a year, paid monthly. Hours: approx. 7–8 hrs a month. (Registered 05 August 2021; updated 24 February 2022)

3. Gifts, benefits and hospitality from UK sources

Name of donor: Carlton Club

Address of donor: 69 St. James's Street, London SW1A 1PJ

Amount of donation or nature and value if donation in kind: One-off joining fee waived to the value of £1,700

Date received: 1 December 2021

Date accepted: 1 December 2021

Donor status: company, registration 00573221

(Registered 20 December 2021)

8. Miscellaneous

From 26 June 2020, a member of Ipswich Towns Fund Board. (Registered 29 October 2020)

From 19 July 2021, share options anticipated to be available at a future date in Kanabo Group PLC. (Registered 19 August 2021)

9. Family members employed and paid from parliamentary expenses

I employ my mother, Carol Poulter, as Senior Parliamentary Assistant. (Updated 24 February 2022)

Other declared interests

- Member of the British Medical Association;
- Member of Royal College of Psychiatrists;
- Member of Medical Defence Union;

- Employee of South London and Maudsley NHS Trust as set out above under section 1.

Spencer, Dr Ben (Runnymede and Weybridge)

3. Gifts, benefits and hospitality from UK sources

Name of donor: Carlton Club

Address of donor: 69 St. James's Street, London SW1A 1PJ

Amount of donation, or nature and value if donation in kind: £980 discount on membership for 2021

Date received: 1 January 2021 to 31 December 2021

Date accepted: 1 January 2021

Donor status: company, registration 00573221

(Registered 04 January 2021)

Name of donor: Swedish Chamber of
Commerce for the UK

Address of donor: Sweden House, 5 Upper
Montagu Street, London W1H 2AG

Amount of donation or nature and value if
donation in kind: One ticket to attend the
Swedish Chamber of Commerce for the UK's
Impact 2022 event, valued at £297

Date received: 27 May 2022

Date accepted: 27 May 2022

Donor status: company, registration 92069
(Registered 30 May 2022)

Name of donor: Swedish Chamber of
Commerce for the UK

Address of donor: Sweden House, 5 Upper
Montagu Street, London W1H 2AG

Amount of donation or nature and value if donation in kind: Two tickets for the Swedish Chamber of Commerce UK's Royal Gala Dinner, valued at £897 each, total value £1,794

Date received: 27 May 2022

Date accepted: 27 May 2022

Donor status: company, registration 92069

(Registered 30 May 2022)

Other declared interests

- I am a, now, non-practising General Adult Psychiatrist with an endorsement in Liaison Psychiatry
- Member of the Royal College of Psychiatrists (until end of December 2022)
- Member of the Royal College of Physicians
- Previously took part as a panel member on the 2018 Independent Review of the Mental Health Act

- Services of a researcher / Parliamentary Scholar for policy research work provided by the NHS, facilitated by the Royal College of Psychiatrists (Dr Spencer subsequently declared that this support ended after less than a month).
- A family member is a consultant psychiatrist

Walker, Sir Charles (Broxbourne)

2. (a) Support linked to an MP but received by a local party organisation or indirectly via a central party organisation

Name of donor: William Moores

Address of donor: private

Amount of donation or nature and value if donation in kind: £3,500

Donor status: individual

(Registered 21 October 2021)

3. Gifts, benefits and hospitality from UK sources

Name of donor: The Red Spinners Angling Club

Address of donor: 226 Churchgate Road,
Cheshunt EN8 9EQ

Amount of donation or nature and value if
donation in kind: Honorary membership for the
duration of my time as the MP for Broxbourne,
annual value (in 2020) £425

Date received: 1 May 2020

Date accepted: 1 May 2020

Donor status: unincorporated association
(Registered 06 July 2020)

7. (i) Shareholdings: over 15% of issued share capital

From 8 February 2022, ProPolitical Ltd
(dormant). (Registered 11 February 2022)

8. Miscellaneous

From 8 February 2022, unpaid Director of ProPolitical Ltd (dormant). (Registered 11 February 2022)

From 22 April 2022, Trustee of the Chimo Trust CIO, which provides grants to charities or other organisations working to promote and protect the good mental health and well-being of young people. (Registered 25 April 2022)

From 6 June 2022, Chair of the Country Food Trust, a charity with the objective to alleviate food poverty by providing free protein rich meals to those in need. This is an unpaid role. (Registered 06 June 2022)

9. Family members employed and paid from parliamentary expenses

I employ my wife, Fiona Walker, as Office Manager.

Specialist advisers' interests

Professor Kamaldeep Bhui

1) I am Principal Investigator on a National Institute for Health and Care Research Policy Research Programme study on ethnicity and the Mental Health Act.

2) My research generally on ethnicity and the Mental Health Act includes work with several research groups and bodies such as the Royal College of Psychiatrists and this continues.

3) I work with charities such as Centre for Mental Health, Thinkahead, the Royal College of Psychiatrists.

Dr Hugh Jones

I am employed by South London and Maudsley NHS Trust.

Witnesses

The following witnesses gave evidence.
 Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 11 October 2022

Sophie Corlett, Director of External Relations, Mind (The National Association for Mental Health); **Andy Bell**, Deputy Chief Executive, Centre for Mental Health; **Mary Sadid**, Policy Manager, National Survivor User Network; **Lucy Schonegevel**, Associate Director, Policy and Practice, Rethink Mental Illness Q1–21

Alexis Quinn, Manager, Restraint Reduction Network; **Dr Jennifer Kilcoyne**, Clinical Director for Centre for Perfect Care, Mersey Care NHS Foundation Trust Q22–28

Tuesday 18 October 2022

Tim Nicholls, Head of Influencing and Research, National Autism Society; **Dan Scorer**, Head of Policy, Public Affairs, Information & Advice, Mencap; **Gail Petty**, Advocacy Lead, NDTi; **Ms Simone Aspis**, Free Our People Now Project Manager, Inclusion London Q29–41

Wednesday 19 October 2022

Professor Stephani Hatch, Professor of Sociology and Epidemiology, Kings College London; **Dr Jacqui Dyer MBE**, Director, Black Thrive; **Maurice Mcleod**, Chief Executive, Race on the Agenda; **Beverley Stephens**, Community Engagement & Membership Manager, Catalyst 4 Change; **Lily Huggins**, Assistant Head of Operational Development (Advocacy), Gaddum Q42–54

Tuesday 25 October 2022

Jonathan Senker, CEO, VoiceAbility; **Dr Nahed Arafet**, Research Student, School of Languages and Culture, University of Sheffield; **Professor Rose McCabe**, Co-Director, Centre for Mental Health Research - City, University of London; **Dr Lucy Stephenson**, Psychiatrist, Psychotherapist and Clinical Research Associate at the Maudsley Hospital South London NHS Foundation Trust and Research Associate at King's College London

Q55–65

Wednesday 26 October 2022

Professor Sir Simon Wessely, Chair, Independent Review of the Mental Health Act; **Rabbi Baroness Julia Neuberger**, Vice Chair, Independent Review of the Mental Health Act; **Steven Gilbert**, Vice Chair, Independent Review of the Mental

Health Act; **Sir Mark Hedley**, Vice Chair,
Independent Review of the Mental Health
Act

Q66–76

Wednesday 2 November 2022

Dr Arun Chopra, Member of
Independent Review topic group; **Dr**
Mark Buchanan, Chair of Mental Health
Committee, Royal College of Emergency
Medicine; **Dr Chloe Beale**, Consultant
Liaison Psychiatrist, Homerton University
Hospital NHS Trust; **Dr Kevin Stone**,
Associate Professor in Social Work
and practicing Approved Mental Health
Professional

Q77–87

Juliet Lyon CBE, Chair, Independent
Advisory Panel on Deaths in Custody; **Dr**
Ailbhe O'Loughlin, Senior Lecturer, York
Law School, University of York; **Andrew**
Neilson, Director of Campaigns, Howard
League for Penal Reform; **Dr Shubulade**

Smith, Clinical Director for Forensic Services, South London and Maudsley NHS Foundation Trust

Q88–97

Tuesday 8 November 2022

Professor Gavin Davidson, Professor of Social Work, Queen's University, Belfast;

Professor George Szmukler, Emeritus Professor, Institute of Psychiatry, Kings

College London; **Professor Jill Stavert**,

Professor of Mental Health and Capacity Law, Edinburgh Napier University; **Dr**

Lucy Series, Lecturer, School of Policy Studies, Bristol University

Q98–107

Wednesday 9 November 2022

Dr Margaret Flynn, Chair, National Mental Capacity Forum; **Dr Quinton**

Deeley, Consultant Neuropsychiatrist, National Autism Unit and Neuropsychiatry Brain Injury Clinic, South London and Maudsley NHS Trust; Professor Mahesh

Odiyoor, Finance Officer, Faculty of
Intellectual Disabilities, Royal College of
Psychiatrists Q108–120

Charlotte Rainer, Coalition Lead,
Children and Young People's Mental
Health Coalition; **Carolynne Willow**,
Director, Article 39; **Dr Susan Walker**,
Consultant Child and Adolescent
Psychiatrist, Great Ormond Street
Hospital Q121–128

Tuesday 15 November 2022

Kirsty Stuart, Chair of Law Society's
Mental Health and Disability Law
Committee, Law Society; **Professor**
Judy Laing, Professor of Mental Health
Law & Policy, University of Bristol; **Justin**
Leslie (Mental health lawyer and former
parliamentary counsel) Q129–137

Wednesday 16 November 2022

Robert Lewis, Vice Chair, AMHP

(Approved Mental Health Professional)

Leads Network; **Dr Gareth Owen**,

Special Advisor to the Royal College

of Psychiatrists on Mental Health and

Mental Capacity Law, Royal College of

Psychiatrists; **Dr Ruth Allen**, CEO, British

Association of Social Workers; **Carol**

Webley-Brown, RCN Council Member

and Registered Nurse, Royal College of

Nursing

Q138–156

Dr Camilla Parker KC (Hon), Legal &

Policy Consultant, Just Equality

Q157–162

Tuesday 22 November 2022

Jemima Burnage, Deputy Director of

Mental Health, Care Quality Commission

(CQC); **Saffron Cordery**, Interim CEO,

NHS Providers; **Sean Duggan OBE**,

CEO, Mental Health Network of the NHS

Confederation; **Peter Devlin**, Co-Chair of Mental Health, Drug and Alcohol Network, Association of Directors of Adult Social Services (ADASS) Q163–176

Wednesday 23 November 2022

Professor Tim Kendall, National Clinical Director for Mental Health, NHS England;
Dr Roger Banks, National Clinical Director for Learning Disability and Autism, NHS England Q177–184

Maria Caulfield MP, Minister for Mental Health and Women's Health Strategy, Department of Health and Social Care; **David Nuttall**, Deputy Director, Neurodiversity, Disability and Learning Disability, Department of Health and Social Care; **Caroline Allnutt**, Deputy Director, Mental Health Act, Serious Mental Illness and Offender Health, Department of Health and Social Care;
Rt Hon. Damian Hinds MP, Minister of

State, Ministry of Justice; **Anna Lacey**,
Deputy Director, Female Offenders and
Offender Health Policy, Ministry of Justice

Q185–202

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in any form before 00.01am on Thursday 19 January 2023.

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

MHB numbers are generated by the evidence processing system and so may not be complete.

- 1 AMHP (Approved Mental Health Professional) Leads Network (MHB0107)
- 2 AMHP (Approved Mental Health Professional) Leads Network (MHB0057)
- 3 Alcohol Health Alliance UK (MHB0093)
- 4 Arafat, Dr Nahed (Interpreter and academic professional , Independent/University of Sheffield); and Woodin, Dr Jane (Intercultural Communication Programme Lead, University of Sheffield) (MHB0066)
- 5 Article 39 (MHB0106)
- 6 Article 39 (MHB0071)
- 7 Association of Directors of Adult Social Services (ADASS) (MHB0114)

- 8 Baroness Finlay of Llandaff (Past chair of National Mental Capacity Forum, House of Lords) (MHB0032)
- 9 Beale, Dr Chloe (Consultant psychiatrist, East London NHS Foundation Trust) (MHB0090)
- 10 British Association of Social Workers (MHB0026)
- 11 British Psychological Society (MHB0039)
- 12 Care England (MHB0099)
- 13 Care Quality Commission (MHB0011)
- 14 Care Quality Commission (CQC) (MHB0109)
- 15 Centre for Mental Health (MHB0012)
- 16 Children and Young People's Mental Health Coalition (MHB0105)
- 17 Children's Commissioner's Office (MHB0089)
- 18 Crown Prosecution Service (MHB0077)

- 19 Deeley, Dr Quinton (Senior Lecturer in Social Behaviour and Neurodevelopment , IOPPN, King's College London) (MHB0055)
- 20 Department for Health and Social Care (MHB0095) y
- 21 Department for Health and Social Care; and Ministry of Justice (MHB0094)
- 22 Department of Health and Social Care; and Ministry of Justice (MHB0110)
- 23 Dimensions (MHB0111)
- 24 Dimensions UK Ltd (MHB0061)
- 25 Double, Dr Duncan (Retired consultant psychiatrist, n/a) (MHB0028)
- 26 Equality and Human Rights Commission (MHB0016)
- 27 General Medical Council (MHB0009)
- 28 Genetic Alliance UK (MHB0084)
- 29 Giraud-Saunders, Alison (MHB0041)
- 30 Hatch, Professor Stephani (Professor of Sociology and Epidemiology of Mental

- Health , IOPPN, King's College London);
Woodhead, Dr Charlotte (Lecturer , IOPPN,
King's College London); and Onwumere,
Dr Juliana (Senior Lecturer , IOPPN, King's
College London) (MHB0064)
- 31 HM Chief Inspector of Prisons (MHB0079)
- 32 HUNDREDFAMILIES.ORG (MHB0013)
- 33 Health and Social Care Committee, Welsh
Parliament (MHB0085)
- 34 Hertfordshire Partnership University NHS
Foundation Trust (MHB0024)
- 35 Howard League for Penal Reform
(MHB0063)
- 36 Howard, Professor Louise (Professor of
Women's Mental Health , IOPPN, King's
College London); and Trevillion, Dr Kylee
(Senior Lecturer in Women's Mental Health,
IOPPN, King's College London) (MHB0053)
- 37 Humber NHS Foundation Trust; Hull City
Council; and Humber and North Yorkshire
Integrated Care Board (MHB0042)

- 38 Hywel dda University Health Board (MHB0043)
- 39 Inclusion London (MHB0115)
- 40 Independent Advisory Panel on Deaths in Custody (MHB0102)
- 41 Independent Advisory Panel on Deaths in Custody (MHB0083)
- 42 INForMHAA (MHB0033)
- 43 INQUEST (MHB0116)
- 44 Jami (MHB0046)
- 45 Joint Committee on Human Rights (UK Parliament) (MHB0086)
- 46 Justice Select Committee (MHB0081)
- 47 King's College London Centre for Society and Mental Health Lived Experience Advisory Board (MHB0030)
- 48 Laing, Dr Judy (Professor of Mental Health Law & Policy, University of Bristol's Human Rights Implementation Centre) (MHB0108)

- 49 Laing, Dr Judy (Professor of Mental Health Law & Policy, University of Bristol Law School); and Dixon, Dr Jeremy (Senior Lecturer in Social Work, University of Bath School for Social and Policy Sciences) (MHB0080)
- 50 Leslie, Justin (MHB0082)
- 51 Liberation; Inclusion London; and Disability Rights UK (MHB0067)
- 52 Local Government Association (LGA) (MHB0017)
- 53 Marlow, Dr Sally (Engagement and Impact Fellow, King's College London) (MHB0044)
- 54 McCabe, Professor Rose (Professor of Clinical Communication and co-Director, Centre for Mental Health Research - City, University of London) (MHB0047)
- 55 Mencap and the Challenging Behaviour Foundation (MHB0078)
- 56 Metropolitan Police Service (MHB0103)

- 57 Mind (The National Association for Mental Health); and Race on the Agenda (MHB0070)
- 58 Money and Mental Health Policy Institute (MHB0021)
- 59 NAViGO Health and Social Care Community Interest Company (MHB0010)
- 60 NDTi (MHB0100)
- 61 NHS Confederation Mental Health Network (MHB0065)
- 62 NHS England (MHB0113)
- 63 NHS England (MHB0051)
- 64 NHS Providers (MHB0022)
- 65 National Autistic Society (MHB0088)
- 66 National Mental Capacity Forum; and Kirsty Keywood (Senior Lecturer, Centre for Social Ethics and Policy, University of Manchester) (MHB0112)
- 67 National Network of Parent Carer Forums (NNPCF) (MHB0101)

- 68 National Survivor User Network (MHB0074)
- 69 North Yorkshire County Council; and North Yorkshire County Council (MHB0075)
- 70 O'Loughlin, Dr Ailbhe (Senior Lecturer, York Law School, University of York) (MHB0097)
- 71 O'Loughlin, Dr Ailbhe (Senior Lecturer, York Law School, University of York) (MHB0006)
- 72 Our Time (MHB0045)
- 73 Owen, Dr Gareth (Reader in Mental Health, Ethics and Law, IOPPN, King's College London) (MHB0048)
- 74 Parker KC (Hon), Dr. Camilla (MHB0104)
- 75 Parliamentary and Health Service Ombudsman (MHB0023)
- 76 Parole Board for England and Wales (MHB0058)
- 77 Powys Teaching Health Board (MHB0040)
- 78 Prison Reform Trust (MHB0015)
- 79 Quinn, Ms Alexis (Manager, Restraint Reduction Network) (MHB0068)

- 80 Rethink Mental Illness (MHB0076)
- 81 Roberts, Ms Jo (MHB0036)
- 82 Royal College of Nursing (MHB0087)
- 83 Royal College of Psychiatrists (MHB0060)
- 84 SANE (MHB0059)
- 85 Series, Dr Lucy (Senior Lecturer in Law, Cardiff University School of Law and Politics) (MHB0003)
- 86 Sharpe, Professor Michael (Professor of Psychiatry, Oxford University, UK) (MHB0001)
- 87 Simpson, Professor Alan (Professor of Mental Health Nursing , IOPPN, King's College London) (MHB0052)
- 88 Smith, Dr Shubulade (Clinical Senior Lecturer, IOPPN, King's College London);
Dr Stephenson, Lucy (Clinical Research Associate , IOPPN, King's College London);

- and Henderson, Dr Claire (Clinical Reader in Public Mental Health , IOPPN, King's College London) (MHB0050)
- 89 Social Care Wales (MHB0014)
- 90 South London and Maudsley NHS Foundation Trust (MHB0062)
- 91 St Mungo's (MHB0018)
- 92 Sussex Partnership NHS Foundation Trust (MHB0073)
- 93 Szmukler, Professor George (Emeritus Professor of Psychiatry and Society, King's College London) (MHB0020)
- 94 The Children and Young People's Mental Health Coalition (MHB0056)
- 95 The Law Society (MHB0037)
- 96 The National Autistic Society (MHB0038)
- 97 The Royal College of Speech and Language Therapists (MHB0031)
- 98 Veale, Professor David (Consultant Psychiatrist, King's College London, South

London and Maudsley NHS Foundation
Trust, & The Nightingale Hospital, London)
(MHB0004)

99 VoiceAbility (MHB0096)

100 VoiceAbility (MHB0054)

101 Welsh Government (MHB0098)

102 Wessely, Professor Sir Simon (Chair,
Independent Review of the Mental Health
Act) (MHB0092)

103 West London NHS Trust (MHB0007)

104 Women in Prison (MHB0029)

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